Virginia Department of Health Professions
Board of Medicine

Welcome to the Advisory Board on Midwifery

The Virginia Board of Medicine will hold an electronic meeting of the Advisory Board on Midwifery on **October 9, 2020 at 10:00 A.M**. This meeting will be supported by Cisco WebEx Meetings application.

For the best WebEx experience, you may wish to download the Cisco WebEx Meeting application on your mobile device, tablet or laptop in advance of the meeting. Please note that WebEx will make an audio recording of the meeting for posting.

This electronic meeting is deemed warranted under Amendment 28 to HB29 based on that requiring in-person attendance by the Advisory Board members is impracticable or unsafe to assemble in a single location.

Comments will be received during the public hearings and during the board meeting from those persons who have submitted an email to **william.harp@dhp.virginia.gov** no later than 8:00 a.m. on October 5, 2020 indicating that they wish to offer comment. Comment may be offered by these individuals when their names are announced by the chairman.

Whether you are a member of the Advisory Board or a member of the public, you can join the meeting in the following ways.

- **JOIN BY WEBEX**

https://covaconf.webex.com/covaconf/j.php?MTID=m29230c17ae65b8509c8094bf92134cf1
Meeting number (access code): 171 993 7062

- **JOIN BY PHONE**

+1-517-466-2023 US Toll
+1-866-692-4530 US Toll Free
Meeting number (access code): 171 993 7062

TECHNICAL DIFFICULTIES: Should you experience technical difficulties, you may call the following number: (804) 367-4558 for assistance. Any interruption in the telephonic or video broadcast of the meeting shall result in the suspension of action at the meeting until repairs are made and public access is restored.

The Board of Medicine and the Freedom of Information Act Council are interested in your evaluation of the electronic experience of this meeting. You can provide comment via the following form **HERE**.

Advisory Board on Midwifery

Virginia Board of Medicine
October 9, 2020
10:00 a.m.

Advisory Board on Midwifery

Board of Medicine

Friday, October 9, 2020 @ 10:00 a.m.

9960 Mayland Drive, Suite 300, Henrico, VA

Electronic Meeting

ADVISORY BOARD ON MIDWIFERY
Minutes
February 7, 2020

The Advisory Board on Midwifery met on Friday, February 7, 2020 at 10:00 a.m. at the Department of Health Professions, Perimeter Center; 9960 Mayland Drive, Henrico, Virginia, 23233.

MEMBERS PRESENT:	Kim Pekin, CPM, Chair Mayanne Zielinski, CPM Rebecca Banks, CPM
MEMBERS ABSENT:	Natasha Jones, MSC Ami Keatts, MD
STAFF PRESENT:	Michael Sobowale, Deputy for Licensure William L. Harp, MD, Executive Director Elaine Yeatts, DHP Senior Policy Analyst Colanthia Morton, Deputy for Administration Beulah Baptist Archer, Licensing Specialist
GUESTS PRESENT:	Misty Ward, CPM-NA Birth Center Alliance Lindsey Kornya, CPM-River City Midwifery Adrienna Ross, CPM-River City Midwifery Pamela L. Pilch, Esq.-Birth Rights Bar Marcia Santelli-Jones-Birth Rights Bar Marinda Shindler, CPM-VMA

CALL TO ORDER

Kim Pekin called the meeting to order at 10:06 a.m.

EMERGENCY EGRESS PROCEDURES – Dr. Harp announced the emergency egress procedures.

ROLL CALL –Beulah Baptist Archer called the roll, and a quorum was declared.

APPROVAL OF MEETING MINUTES

Kim Pekin moved to approve the May 24, 2019 minutes. The motion was seconded and carried.

ADOPTION OF AGENDA

Mayanne Zielinski moved to adopt the agenda. The motion was seconded and carried.

PUBLIC COMMENT ON AGENDA ITEMS

Misty Ward discussed her Board reprimand for administering medication without the supervision of a physician or other authorized medical professional. She also spoke to the difficulty she has encountered in establishing a collaborative relationship with a physician in order to have access to medication.

Pamela Pilch and Misty Ward spoke to the lack of clarification on procedures for midwives to follow in obtaining a medical professional authorized to pronounce the time of death in cases of fetal demise.

NEW BUSINESS

1. Report of the 2020 General Assembly – Elaine Yeatts

   Ms. Yeatts reviewed several bills of interest to the Advisory Board. No action was required.

   Dr. Brown reported that the General Assembly now prohibits firearms in its meetings. He also mentioned the Governor's efforts to decrease the disparity in prenatal maternal care and infant mortality.

2. Update Guidance Document 85-10 on high-risk pregnancy disclosures.

   Kim Pekin suggested a periodic review of Guidance Document 85-10, which currently contains some errors in formatting.

   Ms. Yeatts stated that guidance documents are reviewed every four years.

   Dr. Harp said staff would review the document and make necessary edits.

3. Access to medications via birth assistants or by physician prescription.

   Rebecca Banks asked for clarification of the definition of the "relationship" referred to in Section 54.1-3303 of the Code of Virginia. Dr. Harp explained that a "bona fide provider-patient relationship" required for prescribing could be established by a

history, physical examination, medication history, providing advice about the medication to be prescribed, and a medical record. It was discussed that a prescriber had to have a bona fide relationship with a patient of a midwife to be able to prescribe for the patient. 54.1-3408(A) and 3408(U) were also discussed. 3408(A) authorizes RN's and LPN's to administer medications written by a prescriber. The prescriber would be required to have a bona fide provider-patient relationship with the patient before prescribing the medication. 3408(U) indicates that the prescriber would need to be present for an unlicensed individual to administer medication.

Kim Pekin moved to add access to medications to the agenda for the June meeting to discuss how to proceed in bringing this issue to the full Board. The June meeting should review other states' laws and regulations on midwives and their access to medication.

Mayanne Zielinski seconded the motion, which carried.

4. Discuss and clarify procedures for known fetal demise resulting in stillbirth

   Dr. Harp said these processes fall within the purview of the Virginia Department of Health, the Office of the Chief Medical Examiner, and the local medical examiners. He said that only physicians, nurse practitioners and physician assistants are authorized to complete death certificates. He suggested that midwives that deliver a stillborn baby try to get in touch with the local medical examiner.

   Mayanne Zielinski suggested that the Board send an email to midwives regarding who can complete death certificates. Dr. Harp offered that this item could be placed in the next edition of the Board Briefs.

NEXT MEETING DATE

June 5, 2020, at 10:00 a.m.

ADJOURNMENT

Kim Pekin moved to adjourn the meeting. The motion was seconded and carried.

_____
Kim Pekin, CPM, Chair

_____
William L. Harp, MD
Executive Director

_____
Beulah Baptist Archer, Licensing Specialist

Report of Regulatory Actions

Board of Medicine

Board	Board of Medicine	
Chapter		**Action / Stage Information**
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Conversion therapy [Action 5412] NOIRA - *Register Date: 8/31/20* Comment closes: 9/30/20
[18 VAC 85 - 21]	Regulations Governing Prescribing of Opioids and Buprenorphine	Waiver for e-prescribing of an opioid [Action 5355] Proposed - *Register* *Date: 9/14/20* *Comment closes: 11/13/20*
[18 VAC 85 - 40]	Regulations Governing the Practice of Respiratory Therapists	CE credit for specialty examination [Action 5486] Fast-Track - *Register* *Date: 8/31/20* *Comment closes: 9/30/20* *Effective: 10/15/20*
[18 VAC 85 - 50]	Regulations Governing the Practice of Physician Assistants	Practice with patient care team physician [Action 5357] Proposed - *Register* *Date: 8/31/20* Comment closes: 10/30/20 Public hearing: 10/8/20
[18 VAC 85 - 160]	Regulations Governing the Registration of Surgical Assistants and Surgical Technologists	(E) Licensure of surgical assistants [Action 5580] Final - *Register Date: 9/14/20* Effective: 10/14/20

Report of the 2020 General Assembly

Board of Medicine

HB 42 Prenatal and postnatal depression, etc.; importance of screening patients.

Chief patron: Samirah

Summary as passed:

Health care providers; screening of patients for prenatal and postpartum depression; training. Directs the Board of Medicine to annually issue a communication to every practitioner licensed by the Board who provides primary, maternity, obstetrical, or gynecological health care services reiterating the standard of care pertaining to prenatal or postnatal depression or other depression and encouraging practitioners to screen every patient who is pregnant or who has been pregnant within the previous five years for prenatal or postnatal depression or other depression, as clinically appropriate. The bill requires the Board to include in such communication information about the factors that may increase susceptibility of certain patients to prenatal or postnatal depression or other depression, including racial and economic disparities, and to encourage providers to remain cognizant of the increased risk of depression for such patients.

HB 362 Physician assistant; capacity determinations.

Chief patron: Rasoul

Summary as passed House:

Capacity determinations; physician assistant. Expands the class of health care practitioners who can make the determination that a patient is incapable of making informed decisions to include a licensed physician assistant. The bill provides that such determination shall be made in writing following an in-person examination of the person and certified by the physician assistant. This bill is identical to SB 544.

HB 471 Health professionals; unprofessional conduct, reporting.

Chief patron: Collins

Summary as passed House:

Health professionals; unprofessional conduct; reporting. Requires the chief executive officer and the chief of staff of every hospital or other health care institution in the Commonwealth, the director of every licensed home health or hospice organization, the director of every accredited home health organization exempt from licensure, the administrator of every licensed assisted living facility, and the administrator of every provider licensed by the Department of Behavioral Health and Developmental Services in the Commonwealth to report

to the Department of Health Professions any information of which he may become aware in his professional capacity that indicates a reasonable belief that a health care provider is in need of treatment or has been admitted as a patient for treatment of substance abuse or psychiatric illness that may render the health professional a danger to himself, the public, or his patients, or that he determines, following review and any necessary investigation or consultation with the appropriate internal boards or committees authorized to impose disciplinary action on a health professional, indicates that there is a reasonable probability that such health professional may have engaged in unethical, fraudulent, or unprofessional conduct. Current law requires information to be reported if the information indicates, after reasonable investigation and consultation with the appropriate internal boards or committees authorized to impose disciplinary action on a health professional, a reasonable probability that such health professional may have engaged in unethical, fraudulent, or unprofessional conduct. This bill is identical to SB 540.

HB 517 Collaborative practice agreements; adds nurse practitioners and physician assistants to list.

Chief patron: Bulova

Summary as passed House:

Collaborative practice agreements; nurse practitioners; physician assistants. Adds nurse practitioners and physician assistants to the list of health care practitioners who shall not be required to participate in a collaborative agreement with a pharmacist and his designated alternate pharmacists, regardless of whether a professional business entity on behalf of which the person is authorized to act enters into a collaborative agreement with a pharmacist and his designated alternate pharmacists. As introduced, this bill is a recommendation of the Joint Commission on Healthcare. This bill is identical to SB 565.

HB 648 Prescription Monitoring Program; information disclosed to Emergency Department Care Coord. Program.

Chief patron: Hurst

Summary as passed:

Prescription Monitoring Program; information disclosed to the Emergency Department Care Coordination Program; redisclosure. Provides for the mutual exchange of information between the Prescription Monitoring Program and the Emergency Department Care Coordination Program and clarifies that nothing shall prohibit the redisclosure of confidential information from the Prescription Monitoring Program or any data or reports produced by the Prescription Monitoring Program disclosed to the Emergency Department Care Coordination Program to a prescriber in an electronic report generated by the Emergency Department Care Coordination Program so long as the electronic report complies with relevant federal law and regulations governing privacy of health information. This bill is identical to SB 575.

HB 908 Naloxone; possession and administration by employee or person acting on behalf of a public place.

Chief patron: Hayes

Summary as passed House:

Naloxone; possession and administration; employee or person acting on behalf of a public place. Authorizes an employee or other person acting on behalf of a public place, as defined in the bill, who has completed a training program on the administration of naloxone or other opioid antagonist to possess and administer naloxone or other opioid antagonist, other than naloxone in an injectable formulation with a hypodermic needle or syringe, in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health. The bill also provides that a person who is not otherwise authorized to administer naloxone or other opioid antagonist used for overdose reversal may administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose. The bill provides immunity from civil liability for a person who, in good faith, administers naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose, unless such act or omission was the result of gross negligence or willful and wanton misconduct. This bill incorporates HB 650, HB 1465, and HB 1466.

HB 1040 Naturopathic doctors; Board of Medicine to license and regulate. (Bill not passed; study by the Board of Health Professions)

Chief patron: Rasoul

Summary as introduced:
Naturopathic doctors; license required. Requires the Board of Medicine to license and regulate naturopathic doctors, defined in the bill as an individual, other than a doctor of medicine, osteopathy, chiropractic, or podiatry, who may diagnose, treat, and help prevent diseases using a system of practice that is based on the natural healing capacity of individuals, using physiological, psychological, or physical methods, and who may also use natural medicines, prescriptions, legend drugs, foods, herbs, or other natural remedies, including light and air.

HB 1059 Certified registered nurse anesthetists; prescriptive authority.

Chief patron: Adams, D.M.

Summary as passed House:

Certified registered nurse anesthetists; prescriptive authority. Authorizes certified registered nurse anesthetists to prescribe Schedule II through Schedule VI controlled substances and devices to a patient requiring anesthesia as part of the periprocedural care of the patient, provided that such prescribing is in accordance with requirements for practice by certified registered nurse anesthetists and is done under the supervision of a doctor of medicine, osteopathy, podiatry, or dentistry. This bill is identical to SB 264.

HB 1084 Surgical assistants; definition, licensure.

Chief patron: Hayes

Summary as enacted with Governor's Recommendations:

Surgical assistants; licensure. Defines "surgical assistant" and "practice of surgical assisting" and directs the Board of Medicine to establish criteria for the licensure of surgical assistants. Currently, the Board may issue a registration as a surgical assistant to eligible individuals. The bill clarifies that requiring the licensure of surgical assistants shall not be construed as prohibiting any professional licensed, certified, or registered by a health regulatory board from acting within the scope of his practice. The bill also establishes the Advisory Board on Surgical Assisting to assist the Board of Medicine regarding the establishment of qualifications for and regulation of licensed surgical assistants.

HB 1147 Epinephrine; every public place may make available for administration.

Chief patron: Keam

Summary as passed:

Epinephrine permitted in certain public places. Allows public places to make epinephrine available for administration. The bill allows employees of such public places who are authorized by a prescriber and trained in the administration of epinephrine to possess and administer epinephrine to a person present in such public place believed in good faith to be having an anaphylactic reaction. The bill also provides that an employee of such public place who is authorized by a prescriber and trained in the administration of epinephrine and who administers or assists in the administration of epinephrine to a person present in the public place believed in good faith to be having an anaphylactic reaction, or is the prescriber of the epinephrine, shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment. The bill directs the Department of Health, in conjunction with the Department of Health Professions, to develop policies and guidelines for the recognition and treatment of anaphylaxis in public places. Such policies and guidelines shall be provided to the Commissioner of Health no later than July 1, 2021.

HB 1260 Athletic Training, Advisory Board on; membership.

Chief patron: Hodges

Summary as introduced:

Advisory Board on Athletic Training; membership. Provides that the one member of the Advisory Board on Athletic Training required to be an athletic trainer who is currently licensed by the Board on Athletic Training and who has practiced in the Commonwealth for not less than three years may be employed in the public or private sector. Currently, the law requires that the member be employed in the private sector.

HB 1261 Athletic trainers; naloxone or other opioid antagonist.

Chief patron: Hodges

Summary as introduced:
Athletic trainers; naloxone or other opioid antagonist. Authorizes licensed athletic trainers to possess and administer naloxone or other opioid antagonist for overdose reversal pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice.

HB 1506 Pharmacists; initiating of treatment with and dispensing and administering of controlled substances.

Chief patron: Sickles

Summary as passed:

Pharmacists; prescribing, dispensing, and administration of controlled substances. Allows a pharmacist to initiate treatment with and dispense and administer certain drugs and devices to persons 18 years of age or older in accordance with a statewide protocol developed by the Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health. The bill directs the Board of Pharmacy to establish such protocols by November 1, 2020, to promulgate emergency regulations to implement the provisions of the bill, and to convene a work group to provide recommendations regarding the development of protocols for the initiating of treatment with and dispensing and administering of additional drugs and devices for persons 18 years of age and older. The bill also clarifies that an accident and sickness insurance policy that provides reimbursement for a service that may be legally performed by a licensed pharmacist shall provide reimbursement for the initiating of treatment with and dispensing and administration of controlled substances by a pharmacist when such initiating of treatment with or dispensing or administration is in accordance with regulations of the Board of Pharmacy.

HB 1683 Diagnostic medical sonography; definition, certification. (Bill not passed; study by Board of Health Professions)

Chief patron: Hope

Summary as introduced:
Diagnostic medical sonography; certification. Defines the practice of "diagnostic medical sonography" as the use of specialized equipment to direct high-frequency sound waves into an area of the human body to generate an image. The bill provides that only a certified and registered sonographer may hold himself out as qualified to perform diagnostic medical sonography. The bill requires any person who fails to maintain current certification and registration or is subject to revocation or suspension of a certification and registration by a sonography certification organization to notify his employer and cease using ultrasound equipment or performing a diagnostic medical sonography or related procedure.

SB 530 Epinephrine; possession and administration by a restaurant employee.

Chief patron: Edwards

Summary as passed:

Possession and administration of epinephrine; restaurant employee. Authorizes any employee of a licensed restaurant to possess and administer epinephrine on the premises of the restaurant at which the employee is employed, provided that such employee is authorized by a prescriber and trained in the administration of epinephrine. The bill also requires the Department of Health, in conjunction with the Department of Health Professions, to develop policies and guidelines for the recognition and treatment of anaphylaxis in restaurants.

SB 757 Medical Excellence Zone Program; VDH to determine feasibility of establishment.

Chief patron: Favola

Summary as passed Senate:

Department of Health; Department of Health Professions Medical Excellence Zone Program; telemedicine; reciprocal agreements. Directs the Department of Health to determine the feasibility of establishing a Medical Excellence Zone Program to allow citizens of the Commonwealth living in rural underserved areas to receive medical treatment via telemedicine services from providers licensed or registered in a state that is contiguous with the Commonwealth and directs the Department of Health Professions to pursue reciprocal agreements with such states for licensure for certain primary care practitioners licensed by the Board of Medicine. The bill requires the Department of Health to set out the criteria that would be required for a locality or group of localities in the Commonwealth to be eligible for the designation as a medical excellence zone and report its findings to the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by November 1, 2020.

The bill states that reciprocal agreements with states that are contiguous with the Commonwealth for the licensure of doctors of medicine, doctors of osteopathic medicine, physician assistants, and nurse practitioners shall only require that a person hold a current, unrestricted license in the other jurisdiction and that no grounds exist for denial based on the acts of unprofessional conduct. The Department of Health Professions is required to report on its progress in establishing such agreements to the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by November 1, 2020. The bill requires the Board of Medicine to prioritize applications for licensure by endorsement as a doctor of medicine or osteopathic medicine, a physician assistant, or a nurse practitioner from such states through a streamlined process with a final determination regarding qualification to be made within 20 days of the receipt of a completed application. This bill is identical to HB 1701.

Guidance document: 85-10 Revised: October 22, 2015

Disclosures by Licensed Midwives for High-Risk Pregnancy Conditions

Virginia Board of Medicine

The Code of Virginia (Law) requires that licensed midwives "disclose to their patients, when appropriate, options for consultation and referral to a physician and evidence-based information on health risks associated with birth of a child outside of a hospital or birthing center." Regulations for Licensed Midwives specify that:

> *Upon initiation of care, a midwife shall review the client's medical history in order to identify pre-existing conditions or indicators that require disclosure of risk for home birth. The midwife shall offer standard tests and screenings for evaluating risks and shall document client response to such recommendations. The midwife shall also continually assess the pregnant woman and baby in order to recognize conditions that may arise during the course of care that require disclosure of risk for birth outside of a hospital or birthing center.*

The risk factors or conditions that require disclosures are listed in regulation. If any of these conditions or factors are presented, the midwife is to:

> *1) Request and review the client's medical history, including records of the current or previous pregnancies;*
>
> *2) Disclose to the client the risks associated with a birth outside of a hospital or birthing center; and*
>
> *3) Provide options for consultation and referral.*

Regulations require that if the risk factors or criteria have been identified that may indicate health risks associated with birth of a child outside a hospital or birthing center, the midwife must provide evidence-based information on such risks and must document in the client record the assessment of all health risks that pose a potential for a high risk pregnancy and, if appropriate, the provision of disclosures and evidence-based information. **The disclosure for intrapartum risk factors should be given to a client at the first prenatal visit.**

For each of the risk factors or conditions identified, this guidance document provides evidence-based information and a format to record in a client's record the disclosure of information and options for consultation and referral.

To access the evidence-based information and disclosure for a particular conditions or risk factor, click on the link in the index below. The midwife may then print the form for that condition or risk factor for presentation and discussion with the client and have the form signed for inclusion in the client record.

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

Guidance document: 85-10 Revised: October 22, 2015

Intrapartum Risk Factors

1. Abnormal fetal cardiac rate or rhythm
2. Active cancer
3. Acute or chronic thrombophlebitis
4. Anemia (hematocrit less than 30 or hemoglobin less than 10 at term)
5. Any pregnancy with abnormal fetal surveillance tests
6. Blood coagulation defect
7. Body Mass Index (BMI) equal to or greater than 30
8. Cardiac disease
9. Chronic obstructive pulmonary disease including asthma
10. Ectopic pregnancy
11. Essential chronic hypertension over 140/90
12. Genital herpes or partner with genital herpes
13. History of hemoglobinopathies
14. HIV positive status with AIDS
15. Inappropriate fetal size for gestation – Macrosomia (Large for gestational age)
16. Inappropriate fetal size for gestation – IUGR (Small for gestational age)
17. Incomplete spontaneous abortion
18. Isoimmunization to blood factors
19. Multiple gestation
20. Persistent severe abnormal quantity of amniotic fluid
21. Platelet count less than 120,000
22. Position presentation other than vertex at term or while in labor
23. Pre-eclampsia/eclampsia
24. Pregnancy lasting longer than 42 completed weeks with an abnormal non-stress test
25. VBAC (vaginal birth after cesarian) previous uterine incision or myomectomy
26. Psychiatric disorders (Mental Health Disorders)
27. Rupture of membranes 24 hours before the onset of labor
28. Seizure disorder requiring prescriptive medication

29. Severe liver disease -- active or chronic
30. Severe renal disease - active or chronic
31. Significant 2nd or 3rd trimester bleeding
32. Significant glucose intolerance (Preexisting diabetes, gestational diabetes, PCOS)
33. Uncontrolled hyperthyroidism
34. Uterine ablation (endometrial ablation)
35. Uterine anomaly

Guidance document: 85-10 Revised: October 22, 2015

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

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[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).

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.
- 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

[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.

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]

- Cerebral palsy

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

- 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]

- Early neonatal and infant death
- Hypoxia

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[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

[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.

- 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 _____

HOME

Guidance document: 85-10 Revised: October 22, 2015

1. ABNORMAL FETAL CARDIAC RATE OR RHYTHM

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.

Disclosure of risks related to: Abnormal fetal cardiac rate or rhythm

Fetal rhythm abnormalities (fetal heart rates that are irregular, too fast or too slow):

- occur in up to 2% of pregnancies
- usually identified by the obstetrical clinician who detects an abnormal fetal heart rate or rhythm using a Doppler or stethoscope
- majority have isolated premature atrial contractions which may spontaneously resolve
- sustained tachyarrhythmia (rapid) or bradyarrhythmia (slow) may be of clinical significance
    - may indicate severe systemic disease
    - may have the potential to compromise the fetal circulation
    - May require intensive antepartum and/or neonatal care

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

HOME

Congenital heart disease: Rhythm abnormalities of the fetus. Lisa K Hornberger, David J Sahn. Heart 2007;93:10 1294-1300 doi:10.1136/hrt.2005.069369

2. ACTIVE CANCER

Preamble:

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Disclosure of risks related to: Active Cancer

Maternal risks:

- maternal infection due to immune suppression,
- deep vein thrombosis and pulmonary embolism during pregnancy and especially after delivery
- hemorrhage at delivery.

Fetal risks:

- Intrauterine growth restriction
- Preterm birth
- Fetal health effects from exposure to maternal medications

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

http://www.nlm.nih.gov/medlineplus/cancerandpregnancy.html J Obstet Gynaecol Can. 2013 Mar;35(3):263-80.

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

3. ACUTE OR CHRONIC THROMBOPHLEBITIS

Preamble:

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> ***"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***

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Deep vein thrombosis (DVT) and pulmonary embolism (PE) are collectively known as venous thromboembolism (VTE). VTE occurs more frequently in pregnant women, with an incidence of 0.5 to 2.0 per 1000 pregnancies, four to five times higher than in the non-pregnant population. The risk for VTE is further elevated in the postpartum period.

The risk for VTE in pregnancy is increased in women with:

- **Prior history of VTE**
- **Advanced maternal age**
- **Collagen-vascular disease, especially antiphospholipid antibody syndrome**
- **Obesity (BMI > 30)**
- **Multiparity**
- **Hypercoaguable state**
- **Nephrotic syndrome**
- **Operative delivery**
- **Prolonged bed rest**
- **Hematologic disorders (hemoglobin SS and SC disease, polycythemia, thrombotic thrombocytopenic purpura, paroxysmal nocturnal hemoglobinuria, and some dysfibrinogenemias).**
- **Maternal medical conditions (diabetes, heart disease, inflammatory bowel disease)**
- **Smoking**
- **Preeclampsia**

Maternal complications:

- **hypoxemia**
- **post-phlebitic syndrome**
- **pulmonary infarction**
- **death**

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

Chisholm CA, James AH, Ferguson JE. Thromboembolic disorders. In: Evans AE, Manual of Obstetrics, 8th edition. 2014, Wolters Kluwers Health.

4. ANEMIA (HEMATOCRIT LESS THAN 30 OR HEMOGLOBIN LESS THAN 10 AT TERM)

Preamble:

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Disclosure of risks related to: Anemia (hematocrit less than 30 or hemoglobin less than 10 at term)

The World Health Organization (WHO) estimates that worldwide, 42% of pregnant women are anemic.[17]

Current knowledge indicates that iron deficiency anemia in pregnancy is a risk factor for preterm delivery and subsequent low birth weight, and possibly for inferior neonatal health. Data are inadequate to determine the extent to which maternal anemia might contribute to maternal mortality.[18]

...a woman who is already anemic is unable to tolerate blood loss that a healthy woman can.[19]

Maternal Risks related to severe or untreated anemia:

- need for blood transfusion(s), resulting from a hemorrhage (significant blood loss) during delivery
- postpartum depression

Fetal/Neonatal Risks related to maternal severe or untreated anemia:

- prematurity
- low-birth-weight
- anemia
- developmental delays

[17] Benoist B, McLean E, Egli I, et al. Worldwide Prevalence of Anaemia 1993-2005. Geneva, Switzerland: World Health Organization; 2008.
[18] Allen, Lindsay H. "Anemia and iron deficiency: effects on pregnancy outcome." The American journal of clinical nutrition 71.5 (2000): 1280s-1284s.
[19] McCormick, M. L., et al. "Preventing postpartum hemorrhage in low-resource settings." International journal of gynecology & obstetrics 77.3 (2002): 267-275.

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

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5. Any Pregnancy with Abnormal Fetal Surveillance Tests

Preamble:

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Disclosure of risks related to: Pregnancy with abnormal Fetal Surveillance Tests

There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery (Price, 2014)." Abnormal stress tests at any point in pregnancy are associated with an increased risk of poor outcomes in pregnancy and during labor and delivery. Babies with diagnosed or undiagnosed anomalies are more likely to have abnormal test results requiring specialized care before or after delivery. Antepartum testing results, with regard to the overall clinical picture, should be taken seriously.

Risks to fetus:

- Stillbirth
- Asphyxia
- Fetal Acidosis
- Low Apgar scores
- Respiratory distress
- Surgical delivery
- Meconium Aspiration
- Death

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

O'Neill, E. T. (2012). Antepartum evaluation of the fetus and fetal well-being. *Clinical Obstetrics and Gynecology , 55* (3), 722.
Preboth, M. (2000). Practice Guidelines ACOG Guidelines on Antepartum Fetal Sruveilannce . *Am Fam Physician* .
Price, A. (2014, January). MSN CNM. Assistant Clinical Professor VCUMC. (B. Sheets, Interviewer)
Singh, T. (2008). The prediction of intra-partum fetal compromise in prolonged pregnancy. *Journal of Obstetrics and Gynecology , 28* (8), 779-782.

Guidance document: 85-10 Revised: October 22, 2015

6. BLOOD COAGULATION DEFECT

Preamble:

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Disclosure of risks related to: Blood coagulation defect

Hereditary thrombophilia, or predisposition to thrombosis, ranges from the common (Factor V Leiden heterozygosity, present in 1-15% of pregnant women) to the rare (antithrombin deficiency occurring in 0.02%). The risk of deep vein thrombosis or pulmonary embolism (collectively known as venous thromboembolism or VTE) ranges from 0.1-7% of pregnancies. The maternal medical history determines the management during pregnancy, which can include anticoagulation with injections of heparin throughout the pregnancy and post-partum period.

The presence of one of these disorders may contribute to the risk of obstetric complications as well, including:

- IUGR
- preeclampsia
- stillbirth
- Frequent fetal surveillance is recommended in most cases, as well as timed delivery in the last week before the estimated date of delivery.

Alternatively, disorders of maternal hemostasis (such as von Willebrand disease) increase the risk of blood loss at delivery, and as hereditary disorders also increase the risk for abnormal bleeding in the newborn.

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date_____

Midwife _____ Date _____

Inherited Thrombophilia in Pregnancy. Practice Bulletin 138, November 2013. American College of Obstetricians and Gynecologists.

7. BODY MASS INDEX (BMI) EQUAL TO OR GREATER THAN 30

Preamble:

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Disclosure of risks related to: Body Mass Index (BMI) equal to or greater than 30

Obesity is defined as having a BMI of 30 or higher. The number of obese women in the United States has increased greatly during the past 25 years. Obesity has also become a major health concern for pregnant women. More than one half of pregnant women are overweight or obese.

Risks of Obesity Include:

- Birth defects – Babies born to obese mothers have an increased risk of having birth defects, such as heart defects and neural tube defects.
- Macrosomia – In this condition, the baby is larger than normal. This can increase the risk of the baby being injured during birth. For example, the baby's shoulder can become entrapped after the head is delivered. Macrosomia also increases the risk of cesarean birth.
- Preterm Birth – Problems associated with a mother's obesity may mean that the baby will need to be delivered early. Preterm infants have an increased risk of health problems, including breathing problems, eating problems, and developmental and learning difficulties later in life.
- Stillbirth – The risk of stillbirth increases the higher the mother's BMI.
- High Blood Pressure
- Preeclampsia – Preeclampsia is a serious illness for both the woman and her baby. Although gestational hypertension is the most common sign of preeclampsia, this condition affects all organs of the body. The kidneys and liver may fail. In rare cases, stroke can occur. The fetus is at risk of growth problems and problems with the placenta. It may require early delivery, even if the baby is not fully grown. In severe cases, the woman, baby, or both may die.

- Gestational Diabetes – High blood glucose (sugar) levels during pregnancy increase the risk of having a very large baby and a cesarean delivery. Women who have had gestational diabetes have a higher risk of having ~~babies~~ diabetes in the future, as do their children.
- Challenges in Prenatal Care – Obesity can make it more difficult for the midwife to assess fetal position and fetal growth.
- Challenges in Labor Management – Obesity can create challenges in moving the woman quickly in the event of an emergency during the birth, and can make auscultation of fetal heart tones more difficult.

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

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Guidance document: 85-10 Revised: October 22, 2015

8. CARDIAC DISEASE

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Disclosure of risks related to: Cardiac Disease

Most women tolerate the cardiovascular changes of pregnancy without difficulty. Pregnancy in a patient with significant cardiac disease is associated with significant risk. Despite occurring in only 0.2-4% of pregnancies, cardiac disease is associated with up to 30% of maternal deaths. A pregnant patient with cardiac disease will benefit from the coordinated care of a multidisciplinary team including perinatologists, cardiologists and anesthesiologists. In particular, adults with repaired congenital heart disease may pose complex management scenarios. They may require specialized cardiac monitoring during labor and birth, and some cardiac conditions are associated with a high enough risk of labor complications that cesarean is recommended.

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

Nanda S, Nelson-Piercy C, Mackillop L. Cardiac disease in pregnancy. Clin Med 2012;12:553-560.

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

Guidance document: 85-10 Revised: October 22, 2015

9. CHRONIC OBSTRUCTIVE PULMONARY DISEASE INCLUDING ASTHMA (1)

Preamble:

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> ***"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.

Asthma affects approximately 4% to 6% of adults of all ages and is one of the most common medical conditions complicating pregnancy.

RISKS

- Preterm birth
- Decreased birth weight
- Increased neonatal and maternal death

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

(1) http://www.glowm.com/section_view/heading/Pulmonary%20Disease%20in%20Pregnancy/item/170#1199

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Guidance document: 85-10 Revised: October 22, 2015

10. ECTOPIC PREGNANCY (1)

Preamble:

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Today, about 1 in 50 pregnancies is ectopic. An ectopic pregnancy occurs when a fertilized egg grows outside of the uterus most commonly in the tube. As the pregnancy grows, it can rupture (burst). If this occurs, it can cause major internal bleeding. This can be life threatening and needs to be treated with surgery.

RISKS

- Fallopian tube damaged, leading to an increased likelihood of having another ectopic pregnancy in the future.
- Ruptured ectopic pregnancy (when the fallopian tube splits) and severe internal bleeding, which can lead to shock.
- Death

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

(1) http://www.webmd.boots.com/pregnancy/tc/ectopic-pregnancy-complications-of-ectopic-pregnancy

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11. ESSENTIAL CHRONIC HYPERTENSION (1)

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Elevated blood pressure, systolic >140 or diastolic >90 or both, that predates conception or is diagnosed before 20 weeks of gestation.

MATERNAL RISKS

- Preterm delivery
- Placental abruption
- Preeclampsia
- Eclampsia
- Seizures
- Maternal congestive heart failure
- Acute renal failure
- Death

FETAL RISKS

- Fetal growth restriction
- Fetal death

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

(1) http://www.nhlbi.nih.gov/health/public/heart/hbp/hbp_preg.htm

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12. GENITAL HERPES OR PARTNER WITH GENITAL HERPES

Preamble:

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Disclosure of Risks Related to: Genital Herpes

Because of its serious and potentially lethal risks to the fetus and neonate, pregnant women and their partners should be tested for ***HSV - Herpes Simplex Virus*** (HSV1 & HSV2).

In women with a previous diagnosis of genital herpes, cesarean delivery to prevent neonatal HSV infection is not indicated if there are NO genital lesions at the time of labor. In an effort to reduce cesarean deliveries performed for the indication of genital herpes, the use of oral acyclovir or valacyclovir near the end of pregnancy to suppress genital HSV recurrences has become increasingly common in obstetric practice. Several studies with small sample sizes suggest that suppressive acyclovir therapy during the last weeks of pregnancy decreases the occurrence of clinically apparent genital HSV disease at the time of delivery, with an associated decrease in cesarean delivery rates for the indication of genital HSV. ***However, because viral shedding still occurs (albeit with reduced frequency), the potential for neonatal infection is not avoided completely, and cases of neonatal HSV disease in newborn infants of women who were receiving antiviral suppression recently have been reported.***[20]

Genital HSV, especially in primary infections, may be dangerous to the neonate if infected during delivery, as it can cause a severe neonatal disease.[21]

Risks of HSV infection to the fetus include:

[20] Kimberlin, David W., et al. "Guidance on management of asymptomatic neonates born to women with active genital herpes lesions." Pediatrics 131.2 (2013): e635-e646.

[21] Meytal Avgil, Asher Ornoy, Herpes simplex virus and Epstein-Barr virus infections in pregnancy: consequences of neonatal or intrauterine infection, Reproductive Toxicology, Volume 21, Issue 4, May 2006, Pages 436-445, ISSN 0890-6238, http://dx.doi.org/10.1016/j.reprotox.2004.11.014.

- intrauterine fetal demise (the death of the fetus while in the uterus)
- skin scars (cutaneous manifestations),
- ophthalmologic findings (chorioretinitis, microphtalmia),
- neurological involvement (causing brain damage)

The clinical presentation of infants with neonatal HSV infection, that is almost invariably symptomatic and frequently lethal, is a direct reflection of the site and extent of viral replication.[22]

Risks of HSV infection to the neonate (newborn) include:

- death
- neurologic (brain) damage (intracranial calcifications, microcephaly, seizures, encephalomacia),
- growth restriction,
- psychomotor development impairment
- skin vesicles or scarring,
- eye lesions resulting in vision loss and/or blindness (chorioretinitis, microphthalmia, cataracts),
- hearing loss and/or deafness

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

[22] Anzivino, Elena, et al. "Herpes simplex virus infection in pregnancy and in neonate: status of art of epidemiology, diagnosis, therapy and prevention." Virol J 6.1 (2009): 1-11.

13. HISTORY OF HEMOGLOBINOPATHIES

Preamble:

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Disclosure of risks related to: History of hemoglobinopathies

Hemoglobinopathies include sickle cell disease and its variants as well as alpha and beta thalassemia. The involvement of a multidisciplinary team including perinatologists, hematologists and anesthesiologists can allow for development of a plan to screen for and manage complications.

Maternal risks include:

- cerebral vein or deep vein thrombosis
- anemia and vaso-occlusive crisis
- pneumonia
- pyelonephritis
- transfusion
- pregnancy induced hypertension
- postpartum infection, sepsis, and systemic inflammatory response syndrome
- cesarean delivery

Fetal risks include:

- preterm birth and its consequences including low birth weight
- intrauterine growth restriction
- abruption placentae
- stillbirth

- genetic risk assessment is also recommended for individuals identified as carriers for hemoglobinopathy, as they may be at risk to have affected offspring.

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- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

Villers, Margaret S., et al. "Morbidity associated with sickle cell disease in pregnancy." American journal of obstetrics and gynecology 199.2 (2008): 125-e1.
Naik, Rakhi P., and Sophie Lanzkron. "Baby on board: what you need to know about pregnancy in the hemoglobinopathies." ASH Education Program Book 2012.1 (2012): 208-214.
John C. Morrison and Marc R. Parrish. "Sickle Cell Disease and Other Hemoglobinopathies" Protocols for High-Risk Pregnancies (2010): 158-159.
American College of Obstetricians and Gynecologists, Practice Bulletin 78, "Hemoglobinopathy in Pregnancy," January 2007

14. HIV POSITIVE STATUS WITH AIDS

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Disclosure of risks related to: HIV positive status with AIDS

HIV transmission from mother to child during pregnancy, labor and delivery, or breastfeeding is known as perinatal transmission and is the most common route of HIV infection in children. When HIV is diagnosed before or during pregnancy, perinatal transmission can be reduced to less than 1% if appropriate medical treatment is given, the virus becomes undetectable, and breastfeeding is avoided.[23]

Recommended medical treatment includes antiretroviral medication taken throughout pregnancy and during labor, regular monitoring of the maternal viral load, cesarean delivery for viral load > 1000 copies/mL, and initiation of antiretroviral medication for the newborn shortly after birth.

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Client_____ Date _____

Midwife_____ Date _____

15. INAPPROPRIATE FETAL SIZE FOR GESTATION – MACROSOMIA (LARGE FOR GESTATIONAL AGE)

[23] http://www.cdc.gov/hiv/risk/gender/pregnantwomen/index.html

Guidance document: 85-10 Revised: October 22, 2015

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Disclosure of Risks Related to: Inappropriate Fetal Size for Gestation – Macrosomia (Large for Gestational Age)

Macrosomia (meaning ***big body***), is arbitrarily defined as a birth weight of more than 4,000 g (8 lb, 13 oz). Also known as ***large for gestational age***, fetal macrosomia complicates more than 10 percent of all pregnancies in the United States.[24]

Risks to the mother related to macrosomia include:

- increased risk of uterine rupture after previous cesarean section or other uterine surgery;
- increased likelihood of induction at or before 40 weeks;
- increased likelihood of an operative delivery: forceps, vacuum, or cesarean section;
- trauma to vagina and/or perineum; including perineal and/or vulvar lacerations, 3rd or 4th degree episiotomy, short or long-term urinary or fecal incontinence;
- increased blood loss and/or postpartum hemorrhage,
- damage to the coccyx (tailbone)

Risks to the baby related to macrosomia at the time of birth include:

- shoulder dystocia (the baby gets stuck at the shoulders after the delivery of the head), which may result in trauma to the baby including:
    - broken clavicle (collar) bone(s);
    - brachial plexus injury, temporary or permanent nerve damage (sensory and motor) to either one or both shoulders, arms, and hands;
    - cerebral palsy;
    - hypoxia, resulting in permanent brain damage;
    - death.
- injuries related to operative delivery (forceps, vacuum, or cesarean section) including:
    - bruising and/or injury to the scalp, head and/or face;

[24] MARK A. ZAMORSKI, M.D., M.H.S.A., and WENDY S. BIGGS, M.D., University of Michigan Medical School, Ann Arbor, Michigan. Am Fam Physician. 2001 Jan 15;63(2):302-307.

  - temporary weakness in the facial muscles (facial palsy);
  - external eye and/or ear trauma;
  - broken clavicle (collar) bone(s);
  - brachial plexus injury (see description above);
  - cerebral palsy;
  - skull fracture;
  - bleeding within the skull;
  - seizures;
  - lacerations (during cesarean section) to the baby's presenting part
- immature lungs and breathing problems, if the due date has been miscalculated and the infant is delivered before 39 weeks of gestation;
- need for special care in the neonatal intensive care unit (NICU);

Risks to the newborn related to macrosomia and later childhood risks:

- higher than normal blood sugar level (impaired glucose tolerance);
- childhood obesity (research suggests that the risk of childhood obesity increases as birth weight increases);
- metabolic syndrome (a group of conditions: increased blood pressure, a high blood sugar level, excess body fat, abnormal cholesterol levels; that occur together, increasing the risk of heart disease, stroke and diabetes later in life.

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- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

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16. INAPPROPRIATE FETAL SIZE FOR GESTATION – IUGR (SMALL FOR GESTATIONAL AGE)

Preamble:

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Disclosure of Risks Related to: Inappropriate Fetal Size for Gestation – IUGR (Small for Gestational Age)

IUGR (Intrauterine Growth Restriction) 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.[25]

Risks to the baby related to IUGR, known as Small for Gestation Age:

- low birth weight (LBW);
- difficulty handling the stresses of vaginal delivery;
- decreased oxygen levels (hypoxia);
- hypoglycemia (low blood sugar);
- low resistance to infection;
- low APGAR scores (a test given immediately after birth to evaluate the newborn's physical condition and determine need for special medical care);
- meconium aspiration (inhalation of stools passed while in the uterus), which can lead to breathing problems, lung surfactant dysfunction, chemical pneumonitis, and persistent pulmonary hypertension;
- trouble maintaining body temperature (hypothermia);
- abnormally high red blood cell count;
- admission to NICU;
- long-term growth problems;
- intrauterine fetal demise (fetal death prior to labor);

[25] Frye, Anne, Holistic Midwifery, Volume I, Labrys Press, Portland, OR, 2006, p. 990

- stillbirth (fetal death during labor or birth).

Risks to the mother related to IUGR:

- increased stress related to fetal monitoring and surveillance (serial ultrasounds and non-stress testing);
- premature labor;
- premature birth (delivery of the fetus before 37 weeks gestation);
- induction and early delivery, before 40 weeks;
- cesarean section.

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

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Guidance document: 85-10 Revised: October 22, 2015

17. INCOMPLETE SPONTANEOUS ABORTION OR INCOMPLETE MISCARRIAGE (10)

Preamble:

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Spontaneous abortion also known as early pregnancy loss refers to a miscarriage that happens before 20 weeks of gestation and is seen in 13% to 20% of all diagnosed pregnancies. Incomplete spontaneous abortion occurs when some tissue is retained in the uterus. Medication or a procedure may be needed to remove the tissue.

STILLBIRTH OR INTRAUTERINE FETAL DEMISE (IUFD)

Fetal death that happens after 20 weeks of gestational age is called stillbirth and has a rate of 3.2 per 1000 births. Medical intervention is needed for delivery.

MATERNAL FETAL RISKS OF EARLY OR LATE FETAL LOSS

- Infection
- Hemorrhage
- Maternal coagulopathy
- Gestational trophoblastic disease
- Rh isoimmunization

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Guidance document: 85-10 Revised: October 22, 2015

- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

(10)http://www.acog.org/Resources And Publications/Practice Bulletins/Committee on Practice Bulletins -- Obstetrics/Management of Stillbirth

(10)http://www.acog.org/Resources And Publications/Patient Education Pamphlets/Files/Early Pregnancy Loss

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18. ISOIMMUNIZATION TO BLOOD FACTORS

Preamble:

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> ***"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.

Disclosure of risks related to: Isoimmunization to blood factors

Pregnant women with a negative Rh blood type (O-, A-, B-, AB-) or with other atypical antibodies have significant fetal and neonatal risk factors. Clinical manifestations of RhD haemolytic disease (HDN) range from asymptomatic mild anemia to hydrops fetalis or stillbirth associated with severe anemia and jaundice.[26]

Risks to the baby related to maternal isoimmunization include:

- destruction of fetal red blood cells (hemolysis);
  - mild to moderate hemolysis manifests as increased indirect bilirubin (red cell pigment).
  - severe hemolysis leads to red blood cell production by the spleen and liver.
- severe anemia;
- hepatic circulatory obstruction (portal hypertension);
- placental edema, interfering with placental perfusion;
- ascites (accumulation of fluid in the abdominal cavity);
- hepatomegaly (swelling of the liver);
- increased placental thickness;
- polyhydramnios (increased amniotic fluid);
- hydrops (fetal heart failure);
- anasarca (extreme generalized edema);
- effusions (abnormal accumulation of fluid);
- intrauterine fetal demise (fetal death);
- stillbirth.

[26] Urbaniak, S. J., and M. A. Greiss. "RhD haemolytic disease of the fetus and the newborn." Blood reviews 14.1 (2000): 44-61.

Guidance document: 85-10 Revised: October 22, 2015

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

19. MULTIPLE GESTATION

Preamble:

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Disclosure of risks related to: Multiple gestation

Maternal risks:

- Anemia
- Hemorrhage
- Preeclampsia
- Gestational diabetes
- Cesarean delivery

Fetal risks:

- Twin-to-twin transfusion syndrome (TTTS) in monochorionic twins
- Vanishing twin/death of one fetus
- Congenital anomalies
- Hydramnios
- Preterm birth
- Malpresentation
- Small for gestational age
- Umbilical cord prolapse
- Neonatal intensive care unit admission

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- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

Rao, Anita, Shanthi Sairam, and Hassan Shehata. "Obstetric complications of twin pregnancies." Best Practice & Research Clinical Obstetrics & Gynaecology 18.4 (2004): 557-576.
Spellacy, W. N. "Antepartum complications in twin pregnancies." Clinics in perinatology 15.1 (1988): 79-86.

Guidance document: 85-10 Revised: October 22, 2015

20. PERSISTENT SEVERE ABNORMAL QUANTITY OF AMNIOTIC FLUID (OLIGOHYDRAMNIOS AND POLYHYDRAMNIOS)

Preamble:

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Disclosure of risks related to: Persistent severe abnormal quantity of amniotic fluid

Oligohydramnios (decreased amniotic fluid) may be caused by fetal anomalies (bladder outlet obstruction, renal agenesis), premature rupture of the membranes, or placental insufficiency occurring de novo or as a consequence of maternal conditions such as hypertension.

Maternal risks:

- antepartum hospitalization
- induction of labor
- cesarean delivery

Fetal risks:

- pulmonary hypoplasia (underdevelopment of the lungs)
- limb contractures
- abnormal fetal heart rate patterns
- acidosis
- neonatal intensive care unit admission
- need for surgical intervention if anomalies present
- stillbirth or neonatal death

Guidance document: 85-10 Revised: October 22, 2015

Polyhydramnios (increased amniotic fluid) is most commonly idiopathic (no identifiable cause) but may be seen in maternal diabetes (especially uncontrolled or with large for gestational age fetus) and with fetal anomalies (diaphragmatic hernia, intestinal obstruction).

Maternal risks:

- cesarean delivery
- post-partum hemorrhage

Fetal risks:

- malpresentation
- neonatal intensive care unit admission
- need for surgical intervention if anomalies present
- neonatal hypoglycemia
- stillbirth and neonatal death

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

Shanks, Anthony, et al. "Assessing the optimal definition of oligohydramnios associated with adverse neonatal outcomes." Journal of Ultrasound in Medicine 30.3 (2011): 303-307.
Magann EF, Sandlin AT, Ounpraseuth ST. Amniotic fluid and the clinical relevance of the sonographically estimated amniotic fluid volume: oligohydramnios. J Ultrasound Med 2011;30:1573-85.
Moore, Thomas R. "Abnormal Amniotic Fluid Volume." Protocols for High-Risk Pregnancies (2010): 399.

21. PLATELET COUNT LESS THAN 120,000

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Disclosure of risks related to: Platelet count less than 120,000

Platelet disorders in pregnancy include those that are time-limited to pregnancy (gestational thrombocytopenia, HELLP syndrome) and those that may pre-date or be newly diagnosed during the pregnancy (idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenic purpura (TTP)). With the exception of gestational thrombocytopenia, all of these platelet disorders place the mother at increased risk for blood loss and need for transfusion.

Gestational thrombocytopenia: occurs in 7-8% of pregnancies and accounts for 70-80% of cases of thrombocytopenia in pregnancy, typically diagnosed in the third trimester, rarely associated with platelet counts below 70,000, not associated with increased risks of bleeding in the mother or fetus, platelet counts return to normal after delivery.

It is important to differentiate gestational thrombocytopenia from more serious platelet disorders:

- ITP: chronic disorder associated with:
  - fluctuating platelet counts that may be lower than 50,000
  - need for steroid or immune globulin treatment and platelet transfusion to avoid excess blood loss at delivery, particularly surgical delivery.
- TTP: acute or chronic disorder generally associated with:
  - severe thrombocytopenia of 20,000 or less
  - hepatic impairment
  - renal impairment
  - CNS impairment
  - increased risk of death for both mother and fetus.

- HELLP syndrome: an acute condition occurring in up to 2% of pregnancies, usually seen in the setting of preeclampsia, and characterized by:
    - thrombocytopenia
    - elevated liver enzymes
    - hemolytic anemia
    - potential for severe maternal illness including:
        - liver failure
        - hepatic subcapsular hematoma
        - excess maternal blood loss
        - seizure
        - maternal death
        - preterm birth
        - intrauterine growth restriction
        - fetal death

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

Gernsheimer T, James AH, Stasi R. How I treat thrombocytopenia in pregnancy. Blood 2013;121:38-47.
Thrombocytopenia during pregnancy. Importance, diagnosis and management. Boehlen F. Hamostaseologie. 2006 Jan;26(1):72-4

22. POSITION PRESENTATION OTHER THAN VERTEX AT TERM OR WHILE IN LABOR

Preamble:

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Presentation Risks

Non-vertex presentations occur in less than 4% of all pregnancies. This would include breech, brow, face, transverse lie, and compound presentations. Non-vertex presentations are associated with congenital abnormalities of the baby, multiple pregnancies, placenta previa, and uterine abnormalities. These associations would increase risk to the mother/baby in addition to the actual risks associated with non-vertex delivery.

C-section has become the standard mode of delivery for babies in non-vertex positions. Physicians and midwives may not have adequate training in the vaginal delivery of non-vertex presentations further increasing the risk of injury or death to both mother and baby. A transverse presentation is considered incompatible with vaginal delivery. Posterior, Brow, and Face presentations are associated with complicated delivery and increased maternal and/or fetal complications and may require C-section if the fetal position cannot be rotated.

Disclosure of risks related to: Position presentation other than vertex at term or while in labor:

Risks to Babies:

- Low APGAR scores
- Ruptured organs (kidney, liver)
- Neck Trauma
- Genital edema
- Prematurity
- Cord Prolapse
- Respiratory distress
- Stillbirth

- Head entrapment
- Edema to face and skull
- Tracheal damage
- Increased NICU admission rates
- Shoulder/arm trauma
- Hip and leg trauma
- Intracranial hemorrhage
- Death

Maternal Risks:

- C-section
- Prolonged/Dysfunctional labor
- Placenta abruption
- Increased risk of deep lacerations

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Client_____ Date _____

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de Leeuw, J. (2002). Mortality and early morbidity for abdominal and vaginal deliveries in breech presentation. *Journal of Obstetrics and Gynaecology , 22* (2), 127-139.

Tidy, C. R. (2010). *patient.co.uk/doctor/malpresentations*. Retrieved from patient.co.uk.

23. PRE-ECLAMPSIA/ECLAMPSIA

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Disclosure of risks related to Pre-eclampsia:

Pre-eclampsia is a leading cause of death in pregnant women and occurs in 5% of all pregnancies. The management of pre-eclampsia may require medication and monitoring unavailable in an out of hospital setting.

Maternal Risks:

- Hypertension leading to brain injury
- Liver Failure
- Kidney Failure
- HELLP syndrome
- Clotting problems (DIC)
- Pulmonary edema
- Seizure (Eclampsia)
- Stroke
- Placental Abruption
- C-section
- Death

Fetal Risks:

- Small for gestational age (IUGR)
- Premature Birth
- Stillbirth

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American College of Obstetricians and Gynecologists. (2011). *Frequently Aksed Questions: Pregnancy: High Blood Pressure During Pregnancy.* ACOG.
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24. PREGNANCY LASTING LONGER THAN 42 COMPLETED WEEKS WITH AN ABNORMAL STRESS TEST

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Pregnancy is considered to be postdates at 42 weeks of gestation. There is limited research available to outline the risks of a pregnancy continuing beyond 42 weeks ***with*** an abnormal stress test. Current medical standard of practice is that beginning at 41 weeks, a non-stress test (NST) be combined with other indicators of fetal well-being, i.e., amniotic fluid index (AFI) or biophysical profile (BPP). There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery. (Price, 2014)

Maternal Risks:

- Oligohydramnios
- Medical induction
- C-section
- Prolonged labor
- Complicated delivery such as: Shoulder dystocia

Fetal Risk

- Large size leading to risks associated with macrosomia
- uteroplacental insufficiency
- Asphyxia
- Infection
- Neonatal acidemia

- Low Apgar
- Birth Injury
- Stillbirth
- Postmaturity/Dysmaturity syndrome
- Fetal distress
- Meconium Aspirtation
- Death

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

Hilder, C. T. (1998). Prolonged Pregnancy: evaluating gestation-specific risks of fetal and infact mortality. *BJOG* .
O'Neill, E. T. (2012). Antepartum evaluation of the fetus and fetal well-being. *Clinical Obstetrics and Gynecology , 55* (3), 722.
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25. VBAC (VAGINAL BIRTH AFTER CESARIAN) PREVIOUS UTERINE INCISION OR MYOMECTOMY (8)

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Because the uterine scar for most caesarian sections is low on the uterus, women who undergo TOLAC (trial of labor after cesarean), are able to give birth vaginally 60–80% of the time. But if problems arise during TOLAC, the baby may need to be born by emergency cesarean delivery. Because uterine rupture can be sudden and unexpected labor outside of a hospital can delay delivery and increase the risk of injury and death for both mother and baby in an emergency. Some surgery for fibroids can result in a similar risk for uterine rupture. An unknown type of prior uterine scar is a contraindication for TOLAC so review of prior surgical records is essential part of the evaluation.

RISKS

Maternal risks

- Maternal hemorrhage
- Infection
- Thromboembolism
- Placenta accreta
- Death
- Emergency hysterectomy

Fetal risks

- Hypoxic Ischemic Encephalopathy
- Stillbirth

- Perinatal death
- Neonatal death
- Respiratory morbidity
- Transient tachypnea
- Hyperbillirubinemia

The probability that a woman attempting TOLAC will achieve VBAC depends on her individual combination of factors.

Selected Clinical Factors Associated with Trial of Labor after Previous Cesarean Delivery Success

Increased Probability of Success
- Prior vaginal birth
- Spontaneous labor

Decreased Probability of Success
- Recurrent indication for initial cesarean delivery (labor dystocia)
- Increased maternal age
- Non-white ethnicity
- Gestational age greater than 40 weeks
- Maternal obesity
- Preeclampsia
- Short interpregnancy interval
- Increased neonatal birth weight

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- ☐ Decline consultation with a physician regarding my risk factors.

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(8) http://www.webmd.com/baby/tc/vaginal-birth-after-cesarean-vbac-risks-of-vbac-and-cesarean-deliveries

26. PSYCHIATRIC DISORDERS (MENTAL HEALTH DISORDERS)

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Clients with mental health issues such as:

- Depression
- Panic/anxiety
- Obsessive-compulsive traits
- Schizophrenia

should be counseled about the stresses of pregnancy and the postpartum period. Clients who are taking psychiatric medication should be made aware that some potential for birth defects may exist and are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their provider.

Risks associated with pregnancy and psychiatric disorders include:

- Poor maternal health
- Poor outcomes for babies including poor fetal growth and development
- Maternal psychiatric medication side effects
- Increased potential for some birth defects

Clients who are taking psychiatric medication are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their provider.

Guidance document: 85-10 Revised: October 22, 2015

Works Cited

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Client_____ Date _____

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27. RUPTURE OF MEMBRANES 24 HOURS BEFORE THE ONSET OF LABOR (7)

Preamble:

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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.

The risk of prolonged rupture of membranes is chorioamnionitis. The risk increases with the delay between rupture of membranes and delivery.

MATERNAL COMPLICATIONS

- cesarean delivery
- endomyometritis
- wound infection
- pelvic abscess
- bacteremia
- postpartum hemorrhage
- postpartum hemorrhage
- bacteremia most commonly involving GBS

Rarely

- septic shock
- disseminated intravascular coagulation
- adult respiratory distress syndrome

- maternal death

FETAL COMPLICATIONS

- fetal death
- neonatal sepsis

NEONATAL COMPLICATIONS

- perinatal death
- asphyxia
- early onset neonatal sepsis
- septic shock
- pneumonia
- intraventricular hemorrhage
- cerebral palsy

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

(7) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3008318/

(7) http://www.nejm.org/doi/full/10.1056/NEJM199611143352013

Guidance document: 85-10 Revised: October 22, 2015

28. SEIZURE DISORDER REQUIRING PRESCRIPTIVE MEDICATION

Preamble:

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Disclosure of risks related to: Seizure disorder requiring prescriptive medication

Most pregnancies are uneventful in women with epilepsy, and most babies are delivered healthy with no increased risk of obstetric complications in women. When controlled, there does not appear to be an increased risk for intrauterine growth restriction, preeclampsia, preterm birth or stillbirth compared to women without seizure disorder.

Fetal risks:

- With uncontrolled seizures:
  - Intrauterine growth restriction
  - Preterm birth
  - Stillbirth
- Some medications are associated with an increased risk of birth defects

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

Best practice guidelines for the management of women with epilepsy. Crawford, P., Epilepsia. 2005:46 Suppl 9:117-24.
McPherson JA, harper LM, Odibo AO, et al. Maternal seizure disorder and risk of adverse pregnancy outcomes. Am J Obstet Gynecol 2013;208:378.e1-5.
Management of epilepsy during pregnancy. Battino D., Tomson T. Drugs, 2007:67(18):2727-46.

Guidance document: 85-10 Revised: October 22, 2015

29. SEVERE LIVER DISEASE -- ACTIVE OR CHRONIC

Preamble:

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Disclosure of risks related to: Severe liver disease -- active or chronic

Liver disease occurs in approximately 3% of pregnancies. It may be chronic or occurring coincident with pregnancy, such as viral hepatitis or drug-induced hepatotoxicity, or pregnancy specific such as HELLP syndrome, intrahepatic cholestasis of pregnancy or acute fatty liver of pregnancy.

Severe liver disease:

- is usually acute in onset
- can be life-threatening to the mother
- associated with a high risk of stillbirth
- If hypertension has preceded the onset of HELLP syndrome, fetal growth restriction may also be present.

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

Liver Disease in Pregnancy, Cleveland Clinic Disease Management Project, Jamilé Wakim-Fleming, August 10, 2010.
Joshi D, James A, Quaglia A et al. Liver Disease in Pregnancy. Lancet 2010;375:594-605.

Guidance document: 85-10 Revised: 2-7-2020

30. SEVERE RENAL DISEASE -- ACTIVE OR CHRONIC

Preamble:

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Disclosure of risks related to: Severe Renal Disease — Active or Chronic

Renal disease is associated with increased risks of both maternal and fetal adverse outcomes. These risks, which rise with the severity of preexisting renal disease, include:

Maternal:

- Hypertension
- abruptio placentae
- deterioration of renal function including permanent end-stage renal failure;

Fetal:

- Intrauterine growth restriction
- abruptio placentae
- stillbirth

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.

Guidance document: 85-10 Revised: 2-7-2020

☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

Williams DJ, Davison JM. Renal Disorders. In: Creasy & Resnick's Maternal-Fetal Medicine, Principles and Practice. 6th edition, 2009: Saunders Elsevier.

Guidance document: 85-10 Revised: 2-7-2020

31. SIGNIFICANT 2ND OR 3RD TRIMESTER BLEEDING

Preamble:

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> ***"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***

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Significant 2nd or 3rd trimester bleeding is often associated with potentially serious conditions, including placenta previa, placenta abruption, and vasa previa.

Medical management and ultrasound is indicated to rule out and/or monitor potentially serious conditions associated with significant bleeding.

Maternal Risk Factors:

- C-section
- Hemorrhage
- Anemia
- Hypovolemic Shock
- Death
- Coagulation Defects (DIC)
- Damage to Kidneys and Brain

Fetal Risk Factors:

- Poor fetal growth (IUGR)
- Birth Defects

- Premature Birth
- Anemia
- Hypovolemic Shock
- Stillbirth

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

American College of Obstetricians and Gynecologists. (2011).*Frequently Asked Questions in Pregnancy: Bleeding During Pregnancy.* ACOG.
Karim, S. e. (1998). Effects of first and second trimester vaginal bleeding on pregnancy outcome.". *JPMA* .
Nielson, E. M. (1991). The Outcome of Prengancies complicated by bleeding during the second trimester. *Surgery, Gynecology, & Obstetrics* .
Oylese, Y. (2010). Third Trimester Bleeding. *Protocols for High Risk Pregnancies* .

Guidance document: 85-10 Revised: 2-7-2020

32. SIGNIFICANT GLUCOSE INTOLERANCE (PREEXISTING DIABETES, GESTATIONAL DIABETES, PCOS)

Preamble:

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> ***"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***

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Disclosure of risks related to: Significant glucose intolerance

Pre-gestational diabetes mellitus (Type 1 or Type 2) affects approximately 1% of pregnancies, with an incidence rising with the incidence of type 2 diabetes in younger adults. Gestational diabetes is diagnosed in 5-7% of pregnancies.

Risk factors for GDM: occurs more commonly in women with a family history of diabetes, prior personal history of glucose intolerance including prior gestational diabetes, obesity, and maternal age over 25.

Maternal risks:

- Hypertension
- Antepartum hospitalization
- Induction of labor
- Cesarean dèllivery
- Uncontrolled diabetes may result in:
  - kidney damage
  - retinopathy resulting in vision loss
  - peripheral nerve damage.

Fetal risks:

- Even when controlled, pre-gestational diabetes is associated with an increased risk of miscarriage and major congenital anomalies. This risk rises with poorer control around the time of conception.
- Throughout pregnancy, diabetes is associated with increased risks of:

  - hypertensive disorders
  - large for gestational age babies
  - stillbirth
  - abnormal progression of labor
  - cesarean delivery
  - shoulder dystocia with resultant brachial plexus injury
- Due to these risks, more frequent ultrasound examinations and antepartum testing of fetal well-being ~~are prescribed~~ may be indicated.
- In the newborn period
  - hypoglycemia
  - hyperbilirubinemia
  - polycythemia

Timing of delivery:

- Pre-gestational diabetes, and uncontrolled gestational diabetes: between 37 and 39 weeks, individualized
- Controlled gestational diabetes: between 39 and 41 weeks, individualized

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- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

Pre-gestational Diabetes Mellitus. American College of Obstetricians and Gynecologists, Practice Bulletin 60, March 2005.
Gestational Diabetes Mellitus. American College of Obstetricians and Gynecologists, Practice Bulletin 137, August 2013.
Landon MB, Gabbe SG. Gestational Diabetes Mellitus. Obstet Gynecol 2011;118:1379-93.

Guidance document: 85-10 Revised: 2-7-2020

33. UNCONTROLLED HYPERTHYROIDISM

Preamble:

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> ***"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***

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Hyperthyroidism occurs in 0.2% of pregnancies; Graves' disease accounts for 95% of these cases.

The signs and symptoms of hyperthyroidism include nervousness, tremors, tachycardia, frequent stools, excessive sweating, heat intolerance, weight loss, goiter, insomnia, palpitations, and hypertension.

RISKS

- Premature delivery
- Severe preeclampsia
- Heart failure
- Maternal death
- Low birth weight
- Fetal death
- Abnormal thyroid function in the newborn

Thyroid storm is a medical emergency and occurs in 1% of pregnant patients with hyperthyroidism and can be triggered by infection, labor or delivery.

RISKS

- Shock
- Stupor
- Coma

Guidance document: 85-10 Revised: 2-7-2020

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- ☐ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

(1)http://www.acog.org/Resources_And_Publications/Practice_Bulletins/Committee_on_Practice_Bulletins_--_Obstetrics/Thyroid_Disease_in_Pregnancy

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

Guidance document: 85-10 Revised: 2-7-2020

34. Uterine Ablation (Endometrial ablation)

Preamble:

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Disclosure of risks related to Uterine Ablation (Endometrial Ablation):

Endometrial Ablation is a procedure accompanied by sterilization or the strong recommendation for continuous contraception. Pregnancy after ablation is rare and therefore there is little research and the maternal and fetal complications are poorly defined.

Maternal Risks:

- Miscarriage
- Placenta acreta
- Manual/Surgical removal of placenta
- Hemorrhage
- Uterine rupture
- C-Section
- Hysterectomy
- Death

Fetal Risks:

- Prematurity
- Death
- Possible increase in anomalies

Guidance document: 85-10 Revised: 2-7-2020

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- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

American College of Obstetricians and Gynecologists. (2013).*Frequently Asked Questions: Special Procedures: Endometrial Ablation.* ACOG.
Jenny, S. L. (2006). Pregnancy after endometrial ablation: English literature review and case report . *The Journal of Minimally Invasive Gynecology , 13* (2), 88-91.
Laberge P. (2008, Oct). Serious and deadly complications from pregnancy after endometrail ablation reports and review of the literature. *J Gynecology Obstertics Biological Reproduction (Paris)* .

Guidance document: 85-10 Revised: 2-7-2020

35. UTERINE ANOMALY

Preamble:

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Disclosure of risks related to: Uterine anomaly

Women with a uterine anomaly (uterine septum, unicornuate uterus, bicornuate uterus, uterine didelphys) are at risk for

- PTB (preterm birth)
- Fetal presentation other than vertex
- Hemorrhage
- Retained placenta
- Kidney malformation

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

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Virginia Board of Medicine
PROPOSED - 2021 Board Meeting Dates

Full Board Meetings

February 18-20	DHP/Richmond, VA	Board Rooms TBA
June 24-26	DHP/Richmond, VA	Board Rooms TBA
October 14-16	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Executive Committee Meetings

April 9	DHP/Richmond, VA	Board Rooms TBA
August 6	DHP/Richmond, VA	Board Rooms TBA
December 3	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Legislative Committee Meetings

January 15	DHP/Richmond, VA	Board Rooms TBA
May 21	DHP/Richmond, VA	Board Rooms TBA
September 3	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 1:00 p.m.

January 6	May TBA	September 29
February 10	June 9	October 23
March 10	July 21	November (TBA)
April 21	August 18	December (TBA)

Times for the Credentials Committee meetings - TBA

TBA

Advisory Board on:

Behavioral Analysts			**10:00 a.m.**
Mon –January 25	May 24	October 4	
Genetic Counseling			**1:00 p.m.**
Mon - January 25	May 24	October 4	
Occupational Therapy 10:00 a.m.			
Tues - January 26	May 25	October 5	
Respiratory Care			**1:00 p.m.**
Tues - January 26	May 25	October 5	
Acupuncture			**10:00 a.m.**
Wed - January 27	May 26	October 6	
Radiological Technology			**1:00 p.m.**
Wed - January 27	May 26	October 6	
Athletic Training			**10:00 a.m.**
Thurs - January 28	May 27	October 7	
Physician Assistants			**1:00 p.m.**
Thurs - January 28	May 27	October 7	
Midwifery			**10:00 a.m.**
Fri - January 29	May 28	October 8	
Polysomnographic Technology			**1:00 p.m.**
Fri - January 29	May 28	October 8	
Surgical Assisting			**TBA**
TBA	TBA	TBA	