Connecticut Childbirth and Women's Center

Health History Form

Name _____ Date of birth _____ Age _____

Preferred pronoun: _____ Ethnicity / Race: _____

1. Social history

What is your occupation and work environment? _____

Relationship status (please circle): Single Married Separated Divorced Widowed Co-habiting Domestic partnered

2. Medication History

List any current medications and dosage (including over-the- counter and vitamins/herbs/supplements):
Are you allergic to any medications/foods/agents?

3. Menstrual history

First day of last menstrual period: _____

Age at first period: _____

Age when periods stopped, if menopausal: _____

Number of days between periods: _____

How many days do you bleed for each period? _____

Do you have any problems with your periods?

_____

_____

_____

_____

4. Sexual history

Are you currently involved in any kind of sexually activity? Y N
Current sex partner(s) is/are: Male Female Both
How long have you been sexual with your partner(s)? How many partners have you had in the past year?
Have you ever experienced sexual, verbal, or physical abuse?
Pain with sex? Problems with interest in or enjoying sex?

5. Pregnancy history

Date of Birth, Miscarriages, Terminations	Weeks Gestation	Gender	Length of labor	Place of Birth	Birth Weight	Type of Birth Vaginal or Cesarean, Complications	Breastfed	If so, when did you stop?
							Y / N	
							Y / N	
							Y / N	
							Y / N	
							Y / N	

Tell us about your breast feeding experience or difficulty with breastfeeding _____

_____

_____

Connecticut Childbirth and Women's Center

Health History Form

6. Contraceptive history

How do you avoid pregnancy? _____ Are you interested in birth control? _____

How long have you used this method? _____ Is this method working well for you? _____

Previous method(s) of birth control? _____

7. Perimenopause / Menopause history

Leaking urine? Y N When did it start?	How often?
Hot flashes or night time sweats?	
Pain or discomfort with urine?	
Memory loss?	
Have you ever taken hormone therapy?	
Have you had a Bone density (Dexa) scan? Y / N	When?
Have you had a colonoscopy? Y /N	When?
Have you ever had a mammogram? Y /N	When?
Family h/o Osteoporosis? Y / N	

8. Gynecological history

Date of last Pap test: _____ Result: _____ Never had one _____

How you ever had a Colposcopy? Freezing/ Burning / LEEP of the cervix? _____

Have you ever had any of the conditions listed below?

Please circle which one:	When?
Gonorrhea	
Chlamydia	
Syphilis	
Abnormal Pap test	
Genital warts	

Please circle which one:	When?
Genital herpes	
Pelvic inflammatory disease	
Endometriosis	
Ovarian cyst	
Uterine fibroids	

9. Medical history

Have you/do you have any of the following:

	Anemia
	Asthma
	Blood clots
	Bleeding disorders
	Breast lumps/disease
	Broken bones
	Frequent UTIs

	Depression/Anxiety
	Diabetes
	Eating disorders
	Heart disease/murmur
	High blood pressure
	Kidney stones
	Liver disease

	Migraines / Headaches
	Thyroid disorders
	Cancer – type?
	Incontinence
	Other:

Connecticut Childbirth and Women's Center

Health History Form

10. Surgical history

Date	Please list below what procedure was done

11. Cigarette use: Never used ___ Past use ____ Current use _____ Total # years used _____ Interested in quitting? Y / N

12. Substance use

Have you/do you drink alcohol (beer, wine, mixed drinks)? _____ If yes, # of drinks/week - Current: _____ Past: _____

Have you/do you use any recreational drugs? _Y / N _ If yes, what and when? _____

13. Family medical history

Hypertension	Mother / Father / Siblings / Grandparents/ None
Diabetes	Mother / Father / Siblings / Grandparents/ None
Heart Disease	Mother / Father / Siblings / Grandparents/ None
Breast Cancer	Mother / Father / Siblings / Grandparents/ None
Cancer: type?	Mother / Father / Siblings / Grandparents/ None
Bleeding Disorders	Mother / Father / Siblings / Grandparents/ None
Other:	Mother / Father / Siblings / Grandparents/ None
Other:	Mother / Father / Siblings / Grandparents/ None

14. Are you pregnant? Or planning a pregnancy in the next year?

Do you have cats in your home? Are they inside or outside cats?
Chicken pox exposure? vaccine / infection / none
Special diet? i.e. vegan / vegetarian
Are you up to date on vaccines? Y /N Did you get all your childhood vaccines?
Have you traveled out of the country in past 6 months? Y N If so to where?
Have home or work place exposure to chemicals or radiation?

15. Do you or your family member have a history of any other following?

Y / N	Twins
Y / N	Genetic disorders
Y / N	Still birth
Y / N	Babies with heart defects

Y / N	Infertility
Y / N	Babies born with anomalies
	Other:

Name:_____ Date:_____

Domestic Violence Initiative Screening Questionnaire

- Your CCWC Practice group midwives are concerned about your health and safety and so we ask all women the same questions about violence at home
- This is because violence is very common and we want to improve our response to families experiencing violence

Please answer the following *CONFIDENTIAL* questions:

1.	Are you ever afraid of your partner?	YES	NO
2.	In the last year, has your partner hit, kicked, punched or otherwise hurt you?	YES	NO
3.	Have you ever been touched sexually against your will or without your consent?	YES	NO
4.	In the last year, has your partner put you down, humiliated you or tried to control what you can do?	YES	NO
5.	In the last year, has your partner threatened to hurt you?	YES	NO

If you answered *YES* to *ANY* of the above questions, please answer questions 5 and 6 now.

6.	Would you like help with any of this now?	YES	NO
7.	Would you like us to send a copy of this form to your PCP?	YES	NO

PCP Name/Address:_____

_____

_____

_____

Client Signature:

_____

For Midwife to fill in:

DV Risk Status:

Domestic Violence not identified ○
Domestic Violence identified, refused help ○
Domestic Violence identified, help provided ○

Provided With:

Contact phone numbers for DV ○
Written information for DV ○
Referral to community DV service ○
Other referral:_____

_____

_____

_____

_____

_____

_____

For Midwife to fill in:

Screening Not Completed Due to:

Presence of partner ○
Presence of family member/friend ○
Absence of interpreter ○
Woman refused to answer ○

Additional comments:_____

_____

_____

_____

_____

_____

Signature of Provider:

_____

Date:

_____

Risk Assessment Form

Patient Name:_____Date:_____

It is important that you complete this form as best as you can. Your family and personal history of disease can impact your provider's recommended plan of care today as well as in the future.

Have you been diagnosed with any of the following:	**Age diagnosed**
Breast or ovarian cancer (any age)	
Metastatic prostate cancer (cancer that spread or considered aggressive	
Colon cancer before age 65	
Uterine/endometrial cancer before age 65	
Pancreatic cancer	

For this, please consider these relatives and their ages of diagnosis: *Mother, Father, Siblings, Children, Half-siblings, Aunts/Uncles, Grandparents, Nieces/Nephews, Great Aunts/Uncles, Great Grandparents, first cousins*. Do your best to narrow down the decade of diagnosis (30's40's, 50's, OR if they were diagnosed before or after age 50).,

Have any family members listed above been diagnosed with:			**List family member and age diagnosed**
Y	N	**Breast** cancer before **age 50**	
Y	N	**Ovarian Cancer** at any age	
Y	N	**Pancreatic** cancer at any age	
Y	N	**Male breast** cancer	
Y	N	**Metastatic prostate** cancer in a family member at any age	
Y	N	2 Breast cancers in one person (same or different breast)	
Y	N	**Colon** cancer diagnosed **before age 50**	
Y	N	Many colon polyps (at least 20 cumulative adenomas/precancerous)	
Y	N	**Uterine/endometrial** cancer diagnosed **before age 50**	
Y	N	3 or more of the following cancers at any age, same side of family: colon, rectal, uterine/endometrial, brain, gastric/stomach, kidney, renal pelvis/ureter/bladder, sebaceous adenoma, small bowel	

Office Use Only:

Does patient meet criteria for genetic evaluation (ONE YES)? _____ Yes _____N

Patient decision of genetic testing recommendation: Accepted myRisk _____Declined myRisk_____

Patient's Signature: _____Date_____

AABC
AMERICAN ASSOCIATION OF BIRTH CENTERS
Bringing Midwifery to Main Street

Information & Consent Form

1. Title of Data Collection Form: ***American Association of Birth Centers' Perinatal Data Registry™***
2. Administrator: Kate Bauer, MBA and Jennifer Wright, MA
3. Purpose: The purpose of this data set is to:
   a. Help improve and maintain quality of care of childbearing families;
   b. Provide for ongoing and systematic collection of data on normal birth; and
   c. Facilitate research on maternity care practices that support optimal birth.
4. Voluntary Participation: Taking part in this research is voluntary. Whether you take part is up to you. You can choose not to take part. There will be no penalty or loss of benefits to which you are otherwise entitled. You can agree to take part and later change your mind. There will be no penalty or loss of benefits to which you are otherwise entitled.
5. Procedures: Participation in this data collection involves allowing information from your medical record regarding your pregnancy to be entered into a secure online data registry. The care that you receive during your pregnancy, labor, birth and postpartum, and the care that your newborn receives, will not be altered in any way as a result of your participation in this data registry. Your health record from your pregnancy may also be reviewed by one of the project administrators during a site visit to the practice in which you are receiving maternity care in order to confirm that the data entered in the data registry is accurate. Your data will be collected for _____months and the data will be retained indefinitely.
6. Risks: The risks involved with participation in this project are no more than one would experience in regular daily activities. The main risk of the study is that a breach of confidentiality, meaning that someone not authorized to see the records may gain access. There are steps in place to prevent this.
7. Benefits: There are no direct benefits associated with client participation in the registry. Potential benefits of participation in this project include the satisfaction of knowing that you have helped to support the development of midwives, birth centers and the midwifery model of care, thus contributing to making this model of maternity care more widely available to families.
8. Data Collection & Storage: All information about you and your pregnancy will be kept confidential and secure, and only the people from the American Association of Birth Centers working with the project will see your data. No one except your care provider will be able to connect the data collected with you specifically. As required by the federal Privacy Rule (HIPAA), no identifying information will be seen by those conducting the project except your infant's date of birth and your 5-digit zip code. Your data will be kept on file, and may be used later by other researchers who are studying specific parts of birth center or midwifery care. Your information will be completely de-identified prior to being used by any researcher, and all information, including your infant's date of birth and zip code, will be removed. The New England Independent Review Board, which helps oversee the research, may view research records.

NEIRB exemption granted 11-26-2018

NEIRB Version 1.0

9. Alternatives: You can continue to receive your care as normal without being in this study.
10. Cost and Compensation: It will not cost you anything to be in this research. You will not be paid for participation.
11. Contact Information: For questions, concerns or complaints about the data registry, you may contact the Principal Investigator (listed on page 1) or American Association of Birth Centers at 866-54-BIRTH or (215) 234-8068. If you have questions about your rights as a research subject, or other questions, concerns or complaints about the research, you can contact the New England IRB at 1-800-232-9570.
12. Consent Statement: I have read or had read to me the proceeding information describing the project. All of my questions have been answered to my satisfaction. I am 18 years of age or older, or am considered an "emancipated minor" because I am pregnant. I freely consent to participate, and also give permission for data about my newborn to be used. I understand that I am free to withdraw from the project at any time without penalty. I understand that my care during pregnancy will not be affected in any way by whether or not I participate in this project. I have received a copy of this consent form.

Signature of Client _____ Date _____

Signature of Provider _____ Date _____

NEIRB exemption granted 11-26-2018

NEIRB Version 1.0

Connecticut Childbirth & Women's Center
Danbury Midwifery Group
PDR/Patient Data Registry

Part 1: Initial OB Visit

Age:___ Home Zip Code:_____

Primary Insurance:

_____Private Insurance _____Medicare _____Self/Cash Pay

_____Medicaid/Husky _____Other, please specify:_____

Education: Please fill in how many years of the following you completed:

_____Grade School (0-8) Finished:_____Yes ___No
_____High School (0-4) Finished:_____Yes ___No
_____College (0-4) Finished:_____Yes ___No
_____Masters Degree Finished: _____Yes ___No
_____Doctorate Finished: _____Yes ___ No
_____Other higher education; please specify:_____

Maternal Ethnicity:
_____Hispanic or Latino _____NOT Hispanic or Latino

IF HISPANIC OR LATINO: ____Mexican _____Cuban _____Puerto Rican
____South or Central American _____other Spanish culture origin

Maternal Race:
_____White _____Black/African American _____Asian
_____American Indian or Native Alaskan _____Native Hawaiian or Pacific Islander
_____ Mixed Race _____Unknown/Decline to Provide

Marital Status:
_____Single, living with partner _____Single, not living with partner
_____Married, living with partner _____Married, partner temporarily absent (incarcerated, deployed, etc.)
_____Divorced or widowed _____Separated

Patient's PERSONAL Medical history:

_____**NONE**
_____Smoker_____Anorexia/Bulemia___Asthma(requiring RX or in patient treatment)
_____Cervical abnormality (shortened cervix)
_____Chronic Hypertension (requiring RX or in patient treatment)
_____Client herself born preterm (<37 weeks)
_____Thrombophilia
_____UTI's in the past 6 months prior to pregnancy
_____Uterine abnormality (didelphys uterus, septated uterus, etc.)
_____Depression/Psychiatric diseases (requiring RX or in patient treatment)
_____Thyroid Disease (requiring RX)
_____Infertility (treated for this pregnancy, i.e. IVF, medications, etc.)
_____Diabetes specify which type:_____
_____Domestic Violence
_____Sexual Abuse
_____Substance Abuse
_____HIV positive
_____Periodontal disease (bleeding gums, poor dental care)
_____Seizure (requiring treatment or RX)
_____Sexually Transmitted Infections in last 6 months prior to present pregnancy

Pregnancy History: Part One

1. Gravidity: How many pregnancies have you EVER had, including this one and including any pregnancies that may not have resulted in a live baby: _____
2. How many pregnancies have you carried past 20 weeks, NOT including this one:_____
3. How many pregnancies have you had that went past 37 weeks: _____
4. How many pregnancies have you delivered between 25 and 36.6 weeks:_____
5. How many pregnancies have ended in an unplanned miscarriage:_____
6. How many pregnancies have you had an abortion for:_____
7. How many ectopic (fallopian tube) pregnancies have you had:_____
8. How many living children do you have:_____
9. Have any of your children born alive since passed away:_____

Pregnancy History: Part Two

For any of your pregnancies please check off any of the following complications:

_____**NONE** _____Cesarean birth _____Gestational Diabetes
_____Congenital Anomalies/Genetic Diseases _____Hyperemesis
_____Stillbirth _____Babies born <18 months apart

Number of previous Cesareans _____ Number of VBAC's_____

Pregnancy History: Part Two (continued)

_____Intrauterine Growth Restriction _____Low Birth Weight
_____Macrosomia/Large for Gestational Age _____Gestational Hypertension
_____Placental Abruption _____Pyelonephritis
_____Neonatal Death (in first month of life) _____ Retained Placenta
_____Postpartum Mood Disorder or Depression _____Preeclampsia
_____Postpartum Hemorrhage _____ Preterm birth (32-37 weeks)
_____Very preterm birth (<32 weeks) _____Antibody sensitization or problems
_____Shoulder Dystocia _____Vacuum or forcep delivery

If preterm labor/birth please indicate **number of each
_____Preterm labor prior to rupture of membranes
_____Preterm rupture of membranes with induction of labor
_____Medically indicated induction or cesarean (abruption, previa, preeclampsia, non reassuring fetal heart testing, breech, etc.)
_____Elective or social induction of labor
_____Unknown

Planned Place of Birth for Current Pregnancy
_____Birth Center
_____Hospital
_____Undecided

Gestation At Start of Prenatal Care
- First Visit in current pregnancy with any provider:_____
- First Visit in current pregnancy with this practice:_____

Weeks Gestation at Initial Visit at Birth Center: _____
Date of Initial Visit at Birth Center: _____
Estimated Due Date for this Pregnancy: _____

Connecticut Childbirth & Women's Center
CCWC Practice Group
94 Locust Avenue
Danbury, CT 06810

Informed Consent for Participation in Student Education

In an effort to promote knowledge and acceptance of birth center and midwifery based care among health care professionals, the Connecticut Childbirth & Women's Center encourage the involvement of students in our programs of care. These include mainly midwifery students although there is occasionally nursing or medical student involvement. Their roles range from observation to full participation in all aspects of client care. Students are closely supervised by the CNM at all times. Danbury Hospital is a teaching hospital and as such resident staff, medical students and nursing students may be involved in your care should you require care or birth there.

Without midwifery student involvement, however, in all aspects of care we cannot "birth" more midwives!

Should you have any specific concerns regarding a particular student please speak directly with the midwifery director, Cathy Parisi, CNM.

_____
Date

Patient Name:_____Patient Signature:_____

Midwife Signature:_____

Connecticut Childbirth & Women's Center
94 Locust Avenue
Danbury, CT 06810

Coverage of Call Statement

The midwives from the Connecticut Childbirth Center have privileges to provide care for laboring and birthing women at both the Connecticut Childbirth Center and at Danbury Hospital. Consultative and back up services for our practice are provided by Women's Health Associates, a practice made up of four female obstetrician/gynecologists. On occasion back up services are provided by other members of the Obstetrical Staff with privileges at Danbury Hospital.

The midwifery staff makes every effort to attend each birth for the families who come to see us at the midwifery center. Occasionally during the year, however, there are times that clients are laboring at both the birth center and at the hospital. On these few occasions the midwife on call will necessarily need to stay at the birth center while the client laboring at the hospital will be cared for by the obstetrician from our covering practice and the hospital resident staff. The on call midwife will make every effort to come to the hospital as soon as she is finished providing care at the birth center.

Our team of physicians are very aware of the type of care that is provided here at the center. They know that you may have very specific requests and desires for your labor and birth and they will make every effort to cater to your needs within the same safe parameters that the midwifery staff follow.

I understand that if I choose to, or, due to risk factors, must birth at Danbury Hospital, there is a possibility that I may have some or all of my birth care provided for by the obstetricians from Women's Health Associates or another obstetrical practice with privileges at Danbury Hospital.

Patient Name:_____ Patient Signature:_____

Midwife Signature:_____

CONNECTICUT CHILDBIRTH & WOMEN'S CENTER
CCWC PRACTICE GROUP
94 Locust Avenue
Danbury, CT 06810

FINANCIAL AGREEMENT

Our private midwifery practice collects all outstanding balances prior to delivery, generally by your 36th week of pregnancy. An outstanding balance is anything owed by you that insurance will not be covering.

As a patient you are responsible for your insurance deductibles, co-insurance fees, co-pays and any additional fees owed to us by you that are not covered by your insurance. It is your responsibility to call your insurance company to find out your maternity and delivery benefits and to be familiar with your specific plan. Our office staff will contact your insurance company; generally by your second visit with us, to determine your benefits and to obtain authorization for your delivery (if applicable). Once we know what your financial obligation is we will contact you via phone to discuss your responsibilities. At this time we will discuss your plan to fulfill your payment obligations.

If you are a cash payer you must make full payment by the 36th week of pregnancy.

If you transfer in to our practice after the 36th week of pregnancy you will be expected to pay the full amount due at the time of your first visit, whether you are insured or a cash payer.

It is your responsibility to notify the office immediately if your insurance coverage changes or if you no longer have coverage. Failure to meet financial obligations by the 36th week of pregnancy may result in your inability to deliver in our center or may result in you being transferred to another care provider.

You may make installment payments if that is more convenient for you but ALL fees must be made by the 36th week of pregnancy.

I have received, read, and understand the "Financial Agreement" handout for the Connecticut Childbirth & Women's Center and agree to abide by this statement.

_____	_____	_____
Patient Name, printed	Patient signature	Date

Connecticut Childbirth & Women's Center
94 Locust Avenue
Danbury, CT 06810

Phone: 203-748-6000/Fax: 203-748-6771
Email: info@ctbirthcenter.com

Dear Dr/Provider:._____

The _____ family has chosen to deliver their baby in our alternative birth center. We accept only healthy women expecting a normal pregnancy and birth for this out of hospital setting. If at any time either the mother or baby develop problems and can no longer be classified as "low risk"; delivery will be planned at Danbury Hospital where we also have privileges. If indicated after delivery, the mother and baby will be transferred from the center to the hospital setting.

This family has indicated that they would like you to care for their baby after birth. We are a short stay health care facility where the average discharge is 4-6 hours after birth. Therefore, to assure continuity of care, we encourage the family to be seen by you within 48 hours of delivery for your initial examination of the baby. We will notify your office when the baby is born. If you are available and so desire you may examine the infant prior to discharge from the birth center. Otherwise, as advanced practice nurses, we are well qualified to perform an initial examination on the infant, and will do so prior to discharge home.

Through the Connecticut Childbirth & Women's Center the following treatments and laboratory tests are provided:

1. Treatment of the infant's eyes with erythromycin 0.5% ophthalmic ointment
2. Administration of Vitamin K, 1.0mg IM
3. Blood glucose for infants who meet our "At Risk For Hypoglycemia" protocol
4. Blood specimen collection for state mandated Metabolic Screening and Cystic Fibrosis Screening
5. Newborn Hearing Screening as mandated by the State of Connecticut
6. Home visit by qualified RN or nurse-midwife within 24-48 hours of discharge
7. Congenital Coronary Heart Disease (CCHD) screening via pulse oximeter after 24 hours of age
8. One week in-office visit for neonatal weight and assessment
9. Ongoing breastfeeding and lactation support

We require each family during pregnancy to interview and choose a family practitioner/pediatrician. Although we will provide a home visit and one week in-office weight and assessment; the management of the infant's care is the responsibility of the practitioner/pediatrician chosen by the family following discharge from the center. A family may not birth here unless there is an arrangement for the care of the baby following birth with a qualified pediatrician or advanced practice nurse practitioner.

Should you have any questions about the birth center, please feel free to contact us at your convenience.

Sincerely,

Catherine Parisi, CNM
Clinical Director

_____
Pediatric Practice Name

_____
Physician/Practitioner Name

_____
Office Telephone Office Fax

_____
Street Address

_____
City, State, Zip Code

YOU MAY EITHER HAVE YOUR BABY'S PROVIDER READ AND SIGN THIS LETTER OR SIMPLY FILL IN THE PROVIDER'S NAME, ADDRESS, PHONE AND FAX AND RETURN TO THE MIDWIFE OFFICE. A SIGNATURE IS NOT NECESSARY. THE LETTER IS DESIGNED TO LET YOUR BABY'S PROVIDER KNOW WHAT CARE WE WILL GIVE TO YOUR BABY AFTER BIRTH.

Connecticut Childbirth & Women's Center
94 Locust Avenue
Danbury, CT 06810

Home Visit Map

Family Name_____

Home Phone_____ **Cell Phone(s)**_____

Address_____

_____ **Mileage One-Way**_____

Approximate Travel Time One-Way_____

Please give directions from the birth center to your home. You may start the directions from a major highway (I84/Route 7). Please be specific as to identification marks such as signs, mileage, distance between turns, landmarks, color of your house, etc.

The best way to give directions is to be a passenger in the car on the way home from a prenatal visit and make specific notes using routes and mileage, stoplights, etc. Write down exactly how to arrive at your home. Please then use these directions yourself on the next ride home from the birth center to be sure they are accurate and make sense to you (i.e. they actually get you home!).

Additionally, when we come to your home, **please have all loose animals in another room**. While we love cats and dogs (and pigs and ferrets and rabbits), even the most calm and loving pets may become suddenly possessive with a new baby in the home. We appreciate your compliance, thank you. We look forward to visiting you and your new baby after the birth.

If you choose to use a service like MapQuest, PLEASE, drive home using these directions yourself. We have had several instances where the routes and roads referenced no longer existed or were inaccurate. We would prefer to not get lost coming to see you. Thank You!

PLEASE PRINT YOUR DIRECTIONS ON THE BACK OF THIS SHEET

WE WILL DO A HOME VISIT FOR FAMILIES LIVING ONE HOUR OR LESS DRIVING TIME FROM THE BIRTH CENTER. TO DETERMINE THIS WE USE YOUR HOME ADDRESS AND THE 94 LOCUST AVENUE ADDRESS OF THE CENTER IN THE MAPQUEST.COM DIRECTIONS WEBSITE. IF YOU LIVE FARTHER THAN 60 MINUTES DRIVING TIME FROM THE CENTER WE WILL HELP YOU MAKE OTHER ARRANGEMENTS FOR BABY AND MOM AFTERCARE

Connecticut Childbirth & Women's Center
94 Locust Avenue
Danbury, Connecticut 06810

General Consent and Agreement

Childbirth is one of life's peak experiences, and should be viewed as a healthy process. It is a family experience that is shared emotionally, physically, and spiritually. The whole family joins together in welcoming their new member.

As health care providers, our responsibility includes informing childbearing families of their options in birth settings. The setting chosen must be one considered safe and satisfying in meeting the needs expressed by the family.

The childbearing family may choose an out-of-hospital birth if the expectant mother and/or family has:

1. an uncomplicated medical and obstetrical history.
2. a present pregnancy that is proceeding normally.
3. chosen to assume the added responsibilities that go along with an out-of-hospital birth.

Definition: The Connecticut Childbirth and Women's Center is an alternative to the more traditional birth setting in a hospital. **A birth center** is a freestanding, out-of- hospital, short-stay home-like facility providing comprehensive prenatal, birth, postpartum, newborn, and gynecological services for healthy women anticipating a healthy pregnancy and birth. A birth center is not a hospital, and does not have the specialized units, services, or equipment that hospitals have. However, the birth center has available all the equipment, medications, and other medical supplies necessary for normal childbirth in a home-like setting.

A **planned hospital birth** is an alternative that is available for medical reasons, desire/need for a longer postpartum stay, or staffing requirements.

The primary health care providers at our birth center and at planned hospital births are **certified nurse-midwives.** A certified nurse-midwife is a highly trained professional, educated as a registered nurse and certified by the American College of Nurse-midwives after completion of post graduate work. In Connecticut, certified nurse-midwives are licensed as registered nurses, and are also licensed by the Department of Public Health as midwives.

The options for care in pregnancy and birth that we offer are birth in a freestanding birth center, or a planned hospital birth. All care is provided by a team, consisting of certified nurse-midwives, obstetricians, and pediatricians. When you register for care, you can expect that your prenatal care, birth and postpartum care will be provided by the nurse-midwives. The obstetricians whom we have selected as your consultants will be available to see you during your pregnancy and will consult with the nurse-midwives as needed. Should problems arise which require medical care, your care may be managed collaboratively by the nurse-midwife and obstetrician. It is also possible that the obstetrician will take over your care.

Being in the _____ month of pregnancy, and being _____ years of age, I hereby request registration for care at the Connecticut Childbirth and Women's Center with the following understandings:

1. **Physical Examination:** I authorize the nurse-midwives and their medical consultants and nurses to perform, according to the expertise of each discipline, examinations upon my person to confirm general health and pregnancy status. They may obtain the usual specimens and perform the usual diagnostic procedures, including but not limited to the

following: (a) drawing blood, (b) pregnancy tests, (c) urinalysis, (d) blood pressure, (e) internal examination both vaginal and rectal, with and without instruments, and (f) obtaining rectal, vaginal, and cervical specimens, including Pap smear.

I understand that, even when the above are properly and correctly done, there is potential for infection, tissue damage and other unpredictable medical conditions. I agree that the nurse-midwives, medical consultants, and nurses will be responsible for the performance of their own professional acts only, and the test results shall be the responsibility of those who perform them.

2. Authority to treat: I authorize the nurse-midwives, their medical consultants and nurses to treat, administer, or provide as necessary to me and my baby the following: (a) prenatal health care including prenatal education, (b) physical examinations as necessary, (c) blood or other specimens for laboratory tests, (d) oral, intramuscular, subcutaneous and intravenous medications, (e) intravenous infusions, (f) delivery of my baby, (g) episiotomy and repair, (h) postpartum care, including home visits, (i) newborn care initially after birth, and (j) all other procedures related to childbirth as may be deemed necessary. The administration of this care may be in the office, birth center, my home, and elsewhere, including ambulance and hospital. I grant to the nurse-midwives, their medical consultant and nurses full authority to administer all drugs and perform all treatments, diagnostic procedures, and examinations to or upon me and my baby.

In case of emergency, I authorize these professionals to take appropriate measures, and when specialized equipment or hospitalization is required, to transfer me or my baby to the hospital from the birth center. All of the above is to be performed as deemed necessary or advisable by the nurse-midwives, their medical consultants and nurses, in the exercise of her/his professional judgment.

3. Early Transfer: I understand that during the prenatal period you will attempt to recognize "signs" which may indicate that the course of pregnancy might significantly deviate from normal, even though such deviation may not necessarily affect the outcome of my pregnancy. If such is the judgment of the nurse-midwives, the management of my pregnancy may be transferred to the physician consultants, or my care may be managed collaboratively by the nurse-midwives and their consultants.

4. Informed Consent: All childbirth carries some risk to mother and baby, regardless of location. Certain hazards exist when birth occurs in a hospital, rather than in an alternative setting. Likewise, certain hazards exist when birth occurs in an alternative setting rather than in a hospital. Studies of the settings have indicated that the outcomes for low-risk women are comparable when birth occurs in or out of the hospital. We feel that it is necessary that you be fully informed so that you may make a knowledgeable decision about the setting for your birth.

As your birth attendants, we have taken every reasonable precaution to ensure safety, comfort and satisfaction for both mother and baby. However, you must understand that in any particular case, complications may arise suddenly and unpredictably. The following are medical problems which could occur, regardless of the place of birth:

Major Complications

a. Fetal distress - lack of oxygen for the baby while still in the womb.
b. Neonatal asphyxia - lack of oxygen for the baby after birth.
c. Maternal hemorrhage - excess blood loss.
d. Preeclampsia or toxemia - serious condition resulting in high blood pressure and convulsions.

e. Amniotic fluid embolism - amniotic fluid enters the mother's bloodstream causing blood clots, stroke, heart attack, or death.
f. Uterine rupture - uterus splits open.
g. Cardiac arrest - heart stops beating.

Complications Involving the Uterus

a. Placenta praevia - placenta partially or completely covers the opening of the uterus.
b. Placental abruption - placenta separates from wall of uterus before baby is born, resulting in lack of oxygen to baby.
c. Retained placenta - all or part of placenta remains inside uterus, resulting in hemorrhage or infection.
d. Rupture of membranes without labor.

Complications Involving the Pelvis

a. Cephalopelvic disproportion - baby is too large to fit through the birth canal.
b. Shoulder dystocia - shoulders become lodged in pelvis after the baby's head is born.

Complications Involving the Baby

a. Cord prolapse or other cord problems - cord is squeezed, resulting in lack of oxygen to baby.
b. Multiple gestation - more than one baby.
c. Malpresentation - baby is in some position other than the normal head- first position.
d. Stillbirth.
e. Meconium-stained amniotic fluid - baby has bowel movement inside the uterus; can result in severe pneumonia and death if meconium gets into baby's lungs.
f. Congenital anomalies - birth defects.
g. Immaturity or postmaturity - baby is born too early or too late; associated with more complications for baby.
h. Hyperbilirubinemia - baby has too much bilirubin in body after birth, causing jaundice (yellow skin) and, if severe, serious brain damage.

I understand that each of the above complications will be discussed thoroughly with me by the nurse-midwives at a later time in my pregnancy. I am aware that the practice of midwifery, medicine and nursing are not exact sciences, and I acknowledge that no guarantees or assurances have been made to me concerning the results of treatments, examinations, and procedures to be performed.

5. Preparation: We agree to prepare ourselves for pregnancy and childbirth through attendance at childbirth classes and/or independent study. This includes preparation to perform emergency childbirth should labor proceed rapidly. We will prepare ourselves, to the extent possible, to go through birth without sedatives, tranquilizers, or anesthesia.

6. Client History: I understand that the safety of care by the nurse-midwives and of out-of-hospital birth depends upon my medical history and the information which I provide about myself. I affirm that such information is, and will be, to the best of my knowledge, accurate and complete.

7. Transfer to the Hospital: We agree to transfer to Danbury Hospital in the event of a situation in which the nurse-midwife feels that hospital care is required or advised. Should hospitalization become necessary, my records may be made available to the consulting obstetrician or hospital. Depending upon the nature of the complication, my care at Danbury

Hospital will be managed either by the nurse-midwife in consultation with the obstetrician, or exclusively by the obstetrician. All hospital and physician expenses incurred at that time, or at any other time, will be my obligation and are not included in the birth center fees. Because Danbury Hospital is a teaching facility, anyone who plans a hospital birth or who requires transfer to Danbury Hospital should expect to have resident physicians and/or medical students involved in their care.

8. Postpartum Responsibilities: The birth center staff will provide all normal postpartum care, including a home visit within 48-72 hours after birth. The nurse-midwives will perform an initial newborn physical assessment, and the pediatric consultant is available for management of any newborn problems requiring hospitalization immediately after birth. It is my obligation to arrange for pediatric care to begin immediately upon discharge of the infant from the nurse-midwives' care. I understand that my pediatrician/family physician must see the infant within the first week of life if birth occurs in the birth center. A pediatrician/family physician will manage the infant's care in the hospital if the birth occurs there.

Childbirth and the early postpartum period are stressful times for families, both physically and emotionally. We birth parents agree to provide for necessary assistance during the birth and the first week postpartum. This includes obtaining a support person for any older sibling who will be present for the labor and/or birth. I understand that if I am unable to make these arrangements, I will not be eligible for out-of-hospital birth or early discharge from the hospital.

9. Potential Conflict of Interest: The Connecticut Childbirth & Women's Center is owned by two obstetricians, Kenneth Blau MD and Patricia Whitcombe MD. The former is retired from clinical practice, and the latter is a member of Women's Health Associates. We understand that these obstetricians and/or their associates serve as the physician consultants to the birth center and may therefore be involved in the care provided to any birthing mother. We also understand that the nurse-midwives who provide antepartum, intrapartum, and postpartum care to women who seek to give birth at the Connecticut Childbirth & Women's Center were once employed by Women's Health Associates, but are no longer.

10. Malpractice Insurance: Each of the nurse-midwives who will provide care for my unborn child and me carry traditional malpractice insurance, but the facility, Connecticut Childbirth & Women's Center is uninsured.

We have read carefully all of the above information and have had full opportunity to ask questions. All of our questions have been answered to our complete satisfaction. We understand the policies and limitations of the nurse-midwives in an out-of-hospital setting and in the hospital.

We accept our responsibilities in regard to the pregnancy and birth, and share the responsibility for the outcome of this birth.

Mother _____ Date _____

Partner _____ Date _____

Nurse-midwife _____ Date: _____

STATEMENT OF CLIENT RIGHTS AND RESPONSIBILITIES

The staff of the Connecticut Childbirth and Women's Center believes that families and health care providers should work together to provide for safe, high quality care during pregnancy, with each party having certain rights and responsibilities.

Client Rights

It is the right of every client and family to expect and to receive:

1. High quality care and high professional standards which are continually maintained and reviewed.

2. Respectful and dignified treatment at all times.

3. Treatment without discrimination based on race, color, religion, sexual preference, national origin or source of payment.

4. Full information, prior to the administration of any drug or procedure, regarding any potential direct or indirect effects, risks or hazards to herself or her unborn or newborn infant which may result from the use of that drug or procedure.

5. Information, prior to the proposed therapy, of known alternative therapy or of the potential effects of delaying or avoiding a particular therapy.

6. Information regarding areas of uncertainty if there is no properly controlled research that has established the safety of the drug.

7. To determine for herself, without pressure from her attendant, whether she will accept the risks inherent in a proposed therapy or refuse a therapy.

8. Information regarding the name, qualifications, and scope of practice of all of her care providers.

9. Availability of a nurse-midwife, physician and nurse on a 24-hour per day, 7-day per week basis.

10. The opportunity to be accompanied during prenatal care, labor, and birth by significant others of her choosing to provide support.

11. Emergency procedures to be implemented without unnecessary delay.

12. To have her baby cared for in her presence and to have any procedures fully explained as to purpose, risks, and any alternatives.

13. Her health records to be complete, accurate and legible and to have them retained until the child reaches at least the age of majority, or to have the records offered to her before they are destroyed. She shall have control over the release of information from her health records. Her records, and all information regarding her care, shall remain confidential.

14. Full access to her complete health record.

15. Information regarding her and her baby's continuing health care needs following discharge, and the means for meeting these needs.

16. Information regarding cost of care, and counseling on the availability of financial resources if needed.

Client Responsibilities

In addition to understanding her rights, the client should also understand that she too has responsibilities. The client's responsibilities are as follows:

1. Parents are responsible for learning what constitutes good maternity care and for making an effort to obtain the best care possible.

2. The client is responsible for providing complete and accurate information regarding her health history and life style to her care providers.

3. Expectant parents are responsible for discussing the birth setting and assuring that both partners are in agreement as to the chosen setting.

4. Parents are responsible for learning about the physical and psychological process of labor and birth through reading, discussion with staff, and attendance at required classes.

5. The client is responsible for arranging for a support person who will share in her plans and accompany her during labor and birth.

6. The client is responsible for making her preferences known clearly to the health professionals involved in her care in a courteous and cooperative manner.

7. Expectant parents are responsible for listening to their chosen care providers with an open mind, just as they expect the care provider to listen to them openly.

8. Expectant parents are responsible for obtaining information in advance regarding the approximate cost of maternity care, and then meeting this financial commitment.

9. Expectant parents should behave towards those caring for them with the same respect and consideration they themselves would like.

10. Parents are responsible for learning about the mother's and baby's continuing care needs after discharge through reading and attending appropriate prenatal classes. This includes arranging for an help with housework and child care in the postpartum period if necessary.

11. After birth, the parents should put into writing constructive comments and feelings of satisfaction and/or dissatisfaction with the care they received. Good services to families in the future will be facilitated by those parents who take the time and responsibility to express their feelings about the care they received.

All of the previous statements assume a normal pregnancy, birth, and postpartum experience. Expectant parents should realize that if complications develop, there will be an increased need to trust the expertise of the care providers they have chosen. However, if problems occur, the client,

or significant other, still retains responsibility for making informed decisions about her care and that of her baby.

We have read the above rights and responsibilities and fully understand them. We agree to fulfill our responsibilities.

Mother: _____ **Date:** _____

Partner: _____ **Date:** _____

Nurse-midwife: _____ **Date:** _____

Connecticut Childbirth Center
94 Locust Avenue
Danbury, CT 06810

Photographs, Information, Posting Release

In order to foster and promote family centered maternity care, birth center care and midwifery care for childbearing families, and for the purpose of education and social awareness, we consent to the following:

1. Use of biographical (***NOT identifying***) information about/or material about me and/or my pregnancy:
    a. Yes _____
    b. No _____
2. Use of pictures and/or photographs of my child/children and/or me that ***I have supplied*** to the birth center solely for the purpose of display in the center:
    a. Yes _____
    b. No _____
3. Use of information from my medical records regarding my care while a patient of the birth center for statistical reports and publications as long as procedures insure the confidentiality of my record:
    a. Yes _____
    b. No _____
4. Posting the name/weight/delivery date/time of my baby on the "baby board" located in the midwifery office:
    a. Yes _____
    b. No _____
5. Allowing the midwifery staff to post/announce my baby's birth on their "Facebook" page; this would only be the child's first name, weight, gender and date of birth along with comments about the birth such as "lots of hair" or "great job momma" or "another successful VBAC". Family photo as allowed by you, the parent(s):
    a. Yes _____
    b. No _____
    c. I only give permission to post the following about my baby: _____
    _____
    _____
    _____
    _____

Parent's Signatures: _____ _____

CNM Signature: _____

Date: _____

Connecticut Childbirth and Women's Center
Baby Care and Testing

Outlined below are tests and procedures that were designed to help protect your newborn. Testing and procedures are routinely performed before or after birth. Some are mandated by CT state law. For your information we have outlined them below: Please feel free to ask us about these tests and procedures prior to your delivery.

This is a teaching sheet only; it does not give the staff permission to perform a test or procedure.

1. **Erythromycin Eye Prophylaxis:** 0.5% erythromycin ophthalmic ointment in each eye after birth will prevent the baby from potential blindness and/or infection that may result from an undetected gonorrhea or chlamydial infection. There is no test that can be done on a mother close enough to delivery time to rule out the possibility of infection. *The State of Connecticut requires this treatment to be done.*

2. **Newborn Metabolic Screening (PKU) and Cystic Fibrosis (CF):** This blood test is done before discharge from our care; generally at the home visit. It tests for several serious hereditary metabolic and enzymatic diseases that, if untreated, can result in early and permanent brain damage, physical deformities or death. The test is performed after 24 hours of age at the time of the home visit. *The State of CT requires this testing to be done.. There is an $125 fee for these screenings payable to CCWC prior to your delivery, not included in your care or delivery fee.*

3. **Universal Newborn Hearing Screening Program:** A hearing test to identify hearing impaired newborns as early as possible so that the affected newborn can receive treatment as early as possible in order to learn to communicate normally. We perform this testing at the one week after delivery visit in the office. *The State of CT requires this testing to be done.*

4. **Vitamin K Injection:** Newborns who do not receive the vitamin K injection can have bleeding that may be mild or severe, including possible intracranial hemorrhage and/or death. Without the injection, 1 in every 59 to 250 will have bleeding problems for up to 6 months of age. The vitamin K injection greatly lowers the chance of bleeding in the first weeks after birth. In fact, babies who receive the vitamin K injection have only a 1 in 100,000 chance of having this type of bleeding. This is a standard treatment after birth. *The State of CT requires this injection.*

5. **Group Beta Strep Culture:** GBS is a bacteria commonly found in the body. It may be present in a pregnant woman's vaginal or rectal tract and, thus, be passed on to her baby during delivery. A culture will be taken during late pregnancy (35-37 weeks) to determine if you are colonized with this bacteria. For more information look on the American College of Nurse Midwives website: www.acnm.org. *The policies at CCWC require you to be tested for Group Beta Strep during your pregnancy.*

6. **Congenital Coronary Heart Disease Screening:** At the time of the home visit a state mandated test will be done using a painless pulse oximeter on your baby's right hand and either foot. The test can help determine if your baby has a cardiac defect that may require immediate, further attention. *The State of CT requires this test to be done.*

7. **Circumcision:** If you choose to have your son circumcised, it will generally be done around one week of age in our consulting physician's office at 27 Hospital Avenue

_____We plan to circumcise if we have a boy.
_____We do not want our son circumcised.

I/We have read this informational sheet regarding our baby's care and what is considered standard procedures/treatments.

Date: _____

Signature of Parent/s:_____

Signature of CNM:_____

Connecticut Childbirth and Women's Center

94 Locust Avenue

Danbury, CT 06810

CORD BLOOD COLLECTION

Connecticut State Law (Public Health Bill 6678) requires that all pregnant women, by their third trimester, be educated on their cord blood banking options. "Cord Blood" is the blood that remains in the umbilical cord and placenta after the baby has been born. Similar to Bone Marrow, this blood is a rich source of stem cells that are used in many medical treatments today.

1. I am aware that I have the option to save my child's cord blood stem cells at the time of birth. I am aware that there is a limited window to collect this as it will be disposed of as biological waste shortly after birth.
2. I am aware that cord blood has been used for conditions such a Leukemia, anemia and specific cancers and genetic disorders for many years. For these conditions, a sibling or donated sample could be used for transplant.
3. I am aware that the mother and full siblings can also utilize the cord blood stem cells. There is a 75% chance of matching the babies' cord blood for the use in the traditional therapies listed above to match is not guaranteed.
4. I am aware that researchers are currently transplanting cord blood for the treatment of such conditions as heart disease, juvenile diabetes, traumatic brain injury, cerebral palsy, infant strokes, hearing loss and other areas.
5. I am aware that for treatment in these developing therapies my child would NOT be able to use stem cells donated from others, including family members. For the conditions, the child must use their OWN cord blood stem cells.
6. I plan to do the following with my child's cord blood:
   A. __ Dispose of as medical waste
   B. __ Privately bank my child's cord blood.

Patient (Please Print):_____

Signature:_____

Date_____

Connecticut Childbirth & Women's Center
Consent for the Administration of Nitrous Oxide During Labor

I understand the risks and benefits of breathing nitrous oxide for labor and I wish to use this form of client controlled analgesia. I understand that this form of pain management may not remove all sensation of discomfort.

I understand that there are potential side effects of nitrous oxide, which most commonly include dizziness and nausea. When using nitrous oxide I understand that I must have a support person present with me at all times. If I wish to stop using nitrous oxide at any time during labor I may voluntarily discontinue use immediately. I will inform the midwife of this decision.

I understand that I may not use nitrous oxide if I have recently used any drugs or alcohol. I also understand that I may not use nitrous oxide if I have recently had any ear or eye surgery or have a Vitamin B12 deficiency.

I understand that nitrous oxide may make me feel unsteady for brief periods of time. If I need or want to change positions or walk around while using it, I will do so only with assistance from a support person, midwife or registered nurse. I also understand that if I am using nitrous oxide I may also use the tub with direct supervision from a staff member or a member of my support team.

I agree to hold the mouthpiece/mask on my own and will not allow others to hold it to my face or use any other forms of external support (pillows, blankets, straps, etc.) to maintain it on my face.

I will not allow anyone other than myself to use the mouthpiece/mask and understand that anyone observed attempting to or actually utilizing the mask/mouthpiece will be asked to leave the room. Nitrous oxide will also be removed from the room and will no longer be available for my use.

I understand that there could be theoretical risks to nitrous oxide use as well as other pain relieving medication used during pregnancy and labor. I understand that nitrous oxide has been used throughout the world for labor pain control for many decades and is considered safe.

I understand that nitrous oxide is not covered by any insurance and I have paid the $200 fee by cash, personal check or credit card prior to initiation of the nitrous oxide.

I understand and agree to the above and wish to use nitrous oxide for labor pain.

Client printed name	Client signature
Midwife printed name	Midwife signature
Date	Payment Acknowledged/Manner of Payment

Nuvance Health

Please mail to:
Danbury Hospital
Financial Clearance
14 Research Drive
Bethel, CT 06801

Maternity Pre-admission Form

Patient Name (Last, First MI)	Maiden Name	Patient's Mother's First name			Organ Donor? ☐ Y ☐ N
Street Address (City, State, Zip Code)			Home Phone		Cell Phone
Parish/Religion/ name on clergy list?	Age	Birth date	Place of Birth	Race	Language(Primary)
Marital Sta ☐ Married ☐ Single ☐ Widow ☐ Divorced ☐ Legally Separated		Social Security Number	Previously at DHS?		Do you want to be listed in the Patient Directory ☐ Y ☐ N
Doctor's Name		Do you have an Advanced Directive? ☐ Y ☐ N			
Expected Due Date		Type of Delivery expected? ☐ Normal ☐ Cesarean			Do you smoke? ☐ Y ☐ N
Patient Employer		Patient Occupation			Phone
Employer's Address (City State, Zip Code)					
Spouse/Legal Next of Kin		Relationship	Home Phone		Work Phone
Address (City, State, Zip Code)					
Person to Notify in Emergency		Relationship	Home Phone		Work Phone
Address (City, State, Zip Code)					
Spouse Name		Social Security Number	Birth date		Occupation
Spouse Employer					Phone
Spouse Employer's Address					
MEDICARE: NAME EXACTLY AS ON CARD		Disability Date	Retirement Date		ID Number
MEDICAID: NAME EXACTLY AS ON CARD			State or Country		ID Number
Name of Primary Insurance Company					
Insurance Company Address (Street, PO Box, City, State, Zip Code)					
Phone Number	Pre-Cert Phone Number	Policy ID Number		Group ID Number	
Subscriber Name		Group Plan Name/Employer/or Local Union			
Name of Secondary Insurance Company					
Insurance Company Address (Street, PO Box, City, State, Zip Code)					
Phone Number	Pre-Cert Phone Number	Policy ID Number		Group ID Number	
Subscriber Name		Group Plan Name/Employer/or Local Union			