CANNON BUILDING
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STATE OF DELAWARE
BOARD OF MEDICAL LICENSURE AND DISCIPLINE
MIDWIFERY ADVISORY COUNCIL

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INFORMED CONSENT FORM

To be completed by all clients contemplating home birth. Check each box below.

☐I understand that a midwife is not a licensed physician or nurse, and I am not seeking the services of either a doctor or a nurse for my home birth.

☐I acknowledge that home birth can include increased risk of death and disability for mother and child.

☐The risks associated with midwifery care and home birth have been explained to me and I understand those risks.

☐I, the undersigned, consent to receive midwifery care for myself and my newborn during labor, birth, and postpartum in a home setting.

☐I understand that after the birth of the baby, the midwife will assess, monitor, and support the baby during the immediate postpartum period until the baby is in stable condition and during the on-going postpartum period. This includes: assessing overall newborn well-being, monitoring vital signs, assessing and monitoring color, assessing and monitoring tone and reflexes, assessing APGAR scores at 1 and 5 minutes, and at 10 minutes when indicated, assessing and monitoring temperature, monitoring feeding, assessing and monitoring bowel and bladder function, clamping/cutting of umbilical cord, conduction of a newborn physical exam, including weight and measurements, application of eye prophylaxis, and administration of Vitamin K, orally or intramuscularly.

☐I understand it is recommended that every newborn see a pediatrician within 72 hours of delivery.

☐I understand that a transfer may be required to protect the safety of myself or my newborn if signs or symptoms are observed by the midwife that necessitates such transfer. Should such a transfer be required, I understand that the receiving facility will be: _____. This receiving facility is approximately _____ (distance) from my planned home birth location.

The concurrent care policies at the receiving facility are as follows:

_____

_____

The above statement on concurrent care will be repeated orally to me or, if I am incapacitated, my designated agent, in the event of a transfer. My designated agent for this purpose is: _____

Client Signature: _____ Date: _____

Midwife Signature: _____ Date: _____