STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF HEALTH PROFESSIONS
MIDWIFERY COUNCIL
7 Eagle Square, Concord, N.H. 03301
Telephone 603-271-9482 · Fax 603-271-6702

To all NH Certified Midwives,

Greetings from the NH Midwifery Council! The packet that you are receiving includes many critical pieces of information you will need in order to be in compliance with updated and current RSA and rules governing the practice of midwifery in the state of NH. Please read through the list below and then read each piece of information carefully. You may have some of these forms in a previous format or have versions of your own in your charting materials. Please note that the official NH state forms, in some cases, must be used in place of or in addition to any materials that you have been using in the past. The rules which implement the details of our law are a constantly evolving document so as to keep up with both new research and changing requirements of our profession. We have compiled all of these items here in one place for your convenience so that you don't have to go searching or re-creating the wheel. We thank you for your consistent excellence in providing care to the women and families of NH!

First, we provide you with the links to where you may find:

New NH Midwives state website via the OPLC (Office of Professional Licensure and Certification)

https://www.oplc.nh.gov/midwifery/index.htm

Link to our current law:

http://www.gencourt.state.nh.us/rsa/html/XXX/326-D/326-D-mrg.htm

and our updated rules:

http://www.gencourt.state.nh.us/rules/state_agencies/mid.html

I. **RSA 326-D Midwifery Law**
II. Rules:
   - **Mid 500s**
   - **Mid 104.01; NH Midwifery Council contact info**
   - **Mid 203.01; Complaints of misconduct**
   - **Mid 213.01; Settlements**
   - **Mid 217.01; Mid 217.02; Explanation of adopted rules;**
   - **Mid 306.03 Fee Schedule for certifications**

III. Newborn Metabolic screening:

- **Trifold brochure, forms and mailers**: please obtain a supply from DHHS, Linda Kincaid, Newborn screening 603-271-4225
- **Newborn screening refusal form**
- **Refusal to consent to repeat newborn screening**

IV. Newborn hearing screening:

- **Brochure** – please obtain a supply and distribute to clients from Early Hearing Detection & Intervention Program (EHDI) 603-271-1037 or 29 Hazen Dr. Concord, NH 03301.
- **Newborn hearing screening refusal form**, every baby is expected to be screened within 3 weeks or form sent to EHDI.
- **Newborn hearing screening results home/birth centers**- if you don't have the equipment to screen you should be charting that your clients got this information and follow up with if they received screening. Screening can be done with the few midwives that have equipment, local hospitals or local ENT offices.

V. Pulse Oximetry:

- **Pulse Oximetry report**- This should be sent to DPHS NH Screening Program and a copy kept in client's chart. Everyone can obtain equipment on loan for this through Linda Kincaid, 603-271-4225.

VI. VBAC:

- **NH Midwifery Council informed choice for Out of Hospital Vaginal Birth After Cesarean Section (VBAC)**
- NNEPQIN forms can be obtained at https://www.oplc.nh.gov/midwifery/forms.htm, NNEPQIN's patient education brochure entitled "**Birth Choices After Cesarean Section**" and consent form, excluding the signature page, related to in-hospital VBAC and entitled **"Consent for Birth After Cesarean Section".**
- **Mid 503**

All of these forms have the address or contact for where you will be submitting each piece. We plan to have copies of all these forms on the OPLC website.

Sincerely,

Sherry A. Stevens, CPM, NHCM
Chair, NH Midwifery Council

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6503
603-271-4225 1-800-852-3345 Ext. 4225
Fax: 603-271-4519 TDD Access: 1-800-735-2964

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Jeffrey A. Meyers
Commissioner

Lisa M. Morris
Director

NEWBORN HEARING SCREENING REFUSAL FORM

Name of Infant	Birth Date
Street Address	Hospital of Birth
City/State/Zip	Medical Record Number

The benefits of newborn hearing screening and the potential side effects of not being screened have been explained to me.

My decision to refuse hearing screening, after receiving information on newborn hearing screening, was made freely without force or encouragement by my health care provider, my baby's health care provider, facility personnel or State officials.

My decision to have my infants hearing screen at a birth hospital, after receiving information on newborn hearing screening, was made freely without force or encouragement by my health care provider, my baby's health care provider, facility personnel or State official.

Signed	Relationship to Infant
Witnessed by	Date

Original copy to Infant's Medical Record
Copies: Parent, Practitioner, and EHDI Program
2016

Language & Hearing Milestones

Around 3 months

- Quiets to a familiar voice
- Startles to loud sounds
- Cries differently to express needs

Around 6 months

- Looks towards voices
- Begins to respond to name
- Coos, gurgles, giggles

Around 9 months

- Understands a few words & names of family members
- Babbles
- Lifts arms for the word "up"

Around 12 months

- Bounces or moves to music
- Turns exactly toward noises
- Knows 10-50 words
- Stops in response to "no"

Around 18 months

- Follows simple directions
- Knows body parts
- Says 20-50 words
- Begins to understand questions

Contact us for more information:

New Hampshire Department of Health & Human Services
Division of Public Health Services
Bureau of Population Health & Community Services
Maternal & Child Health Section

Early Hearing Detection & Intervention Program

29 Hazen Drive
Concord NH 03301

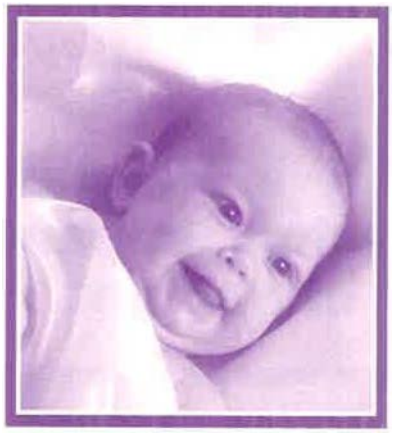
800-852-3345, Ext. 1037 or
603-271-1037

Relay New Hampshire TTY: 711

It's possible to test hearing at any age!

March 2012

Ne\Nborn Hearing Screening



Information for Families

What is Newborn Hearing Screening?

Newborn hearing screening is a quick procedure that checks your baby's hearing and identifies those babies who need further testing. Hearing screening should be done before 1 month of age.

Why is Newborn Hearing Screening important?

Newborn hearing screening is the first step in determining how your baby hears. Babies use their hearing to learn to talk, so it's important to identify hearing loss early. Although it is unlikely that your baby has hearing loss, it is helpful to know how your baby hears as soon as possible.

How is Newborn Hearing Screening done?

Newborn hearing screening is painless and takes about 15 minutes. It should be done while your baby is asleep in a quiet environment. A computer-based screener is used to record each ear's response to sound. It automatically gives a pass or refer result and does not require your baby to respond. There are 2 ways to screen your baby's hearing:

- *Automated Brainstem Response (ABR):* Three sensors are placed on your baby's head and soft sounds are presented through earphones.

- *OtoAcoustic Emissions (OAE):* Soft sounds are presented through foam tips which are placed in your baby's ears.

What do the Newborn Hearing Screening results mean?

Pass means that your baby has adequate hearing at the time of the screening. Some babies who pass the screening may require further testing due to family history or medical conditions.

Refer means that your baby did not pass the screening. If your baby did not pass the first screening, a second one will be done. If your baby does not pass or "refers" on the final hearing screening, your baby will need to be scheduled for diagnostic hearing testing with an audiologist. The audiologist will be able to determine if there is a hearing loss.

Hearing testing should be done anytime there is a concern about a child's hearing.

The following guidelines are intended only as a general educational resource for hospitals and clinicians, and are not intended to reflect or establish a standard of care or to replace individual clinician judgment and medical decision making for specific healthcare environments and patient situations.

VBAC Guidelines

Revised December 2011

This document represents collaboration among the hospitals in Vermont and New Hampshire. It outlines NNEPQIN's collective recommendations for VBAC care, based upon thorough and thoughtful review of the literature. It incorporates ACOG guidelines, and presents a regional definition of provider's "immediate availability" based upon patient risk status. The goal is to maintain the availability of VBAC services throughout the region, while ensuring patient and provider safety. These recommendations apply to VBAC candidates only, and recognize the need to adapt care to the unique circumstances of each case.

Unit Structure:

Each hospital should develop policy and procedure guidelines that reflect the resources and ability of the delivery unit to respond to emergent situations that may develop for patients attempting VBAC. These guidelines should include a description of informed consent, notification, availability of key providers, facilities, and the typical response times for emergency cesarean section.

Each hospital needs to have a system in place for competency review and protocol verification. This can be accomplished in several ways, including but not limited to:

- periodic emergency cesarean drills for staff
- ongoing individual review of emergency cesarean section cases
- regular staff training in the interpretation of fetal heart rate monitoring

These activities will provide ongoing opportunities for quality improvement.

Definitions:

- **Labor:** Regular and painful uterine contractions that cause cervical change.
- **Active Labor**: The cervix is 4-5 cm dilated and there are regular and painful uterine contractions.
- **Adequate Labor:** Contractions every 3 minutes with a 50 torr rise above baseline or contractions every 3 minutes lasting at least 45 seconds that palpate strong.
- **Provider capable of performing a cesarean section:** An obstetrician, surgeon, or family practitioner who is credentialed to perform a cesarean delivery.
- **Admission:** Occurs when labor has been diagnosed, or when decision is made to deliver the patient. Observation to determine if the patient is in labor is not considered admission.
- **Anesthesia:** Refers to a CRNA or anesthesiologist who is privileged by the hospital.

- **OR Team:** One person competent to scrub for a cesarean section and one person competent to circulate during a cesarean section. These may be OR technicians, LNA, CNA, LPN, or RN.

Risk Assessment:

- Each patient should be evaluated for risk factors associated with decreased VBAC success and uterine rupture. (See tables.)
- The association of factors related to an increased risk of uterine rupture has not been able to be translated into the reliable prediction of uterine rupture (1, 2). Patients without risk factors may experience uterine rupture.
- Previous vaginal delivery is associated with higher rates of VBAC success and lower risk of uterine rupture.
- There is limited data on outcomes for women with multiple risk factors present. Some studies suggest that even when multiple risk factors are present, VBAC success rates are often at least 50% or higher (3). All patients should receive counseling about the assumed relative risk for VBAC success and uterine rupture. Management plans for these outcomes should be reviewed with the patient.

Factors Associated With Decreased VBAC Success
Labor induction (3, 4)
Labor augmentation(3, 4)
Short inter-pregnancy interval (3, 4)
Birth weight >4000 gm(3, 4)
Gestational age 41 weeks or greater (3, 4)
Excess maternal weight gain, variously defined (3, 4)
Maternal obesity, variously defined (3, 4)
Recurrent indication for initial cesarean delivery (3, 4)
Unfavorable cervical status at admission (3, 4)
Non-white ethnicity (3, 4)

Factors Associated With Uterine Rupture
Labor induction (5, 6, 7)
Labor augmentation (8, 9, 10)
Short inter-pregnancy interval (16, 17, 18)

Other Factors Investigated for Association with Uterine Rupture
Data insufficient to demonstrate consistent association.
Gestational age 41 weeks or greater (14, 15)
Birth weight >4000 gm (11, 12, 13)
Previous single layer closure of the uterus (19, 20)
Maternal obesity, variously defined (21)
Recurrent indication for initial cesarean delivery (1)
Unfavorable cervical status at admission (1)
Non-white ethnicity (1)
3 or more prior cesarean sections (23, 24)

The Maternal Fetal Medicine Unit Network recently performed a large multi-center trial evaluating VBAC. Based on the data from this study, a nomogram was created to predict VBAC success. A calculator based on this nomogram can be found at the George Washing University Biostatistics Center web site. It may be useful for individualizing the counseling given to patients about VBAC.

http://www.bsc.gwu.edu/mfmu/vagbirth.html

Low Risk Patient: Risk for uterine rupture approximately 0.3-0.7%.

- 1 or 2 prior low transverse cesarean section(s)
- Spontaneous onset labor
- No need for augmentation
- No repetitive FHR abnormalities
- Patients with a prior successful VBAC are especially low risk. However, their risk status escalates the same as other low risk patients.

Medium Risk Patient: Risk for uterine rupture is likely greater than 0.7%.

- Induction of labor
- Oxytocin augmentation
- < 18 months between prior cesarean section and current delivery.
- 3 or more prior low transverse cesarean sections.

High Risk Patient: Patients who have intra-partum signs or symptoms that may be associated with uterine rupture or failure of vaginal delivery (4).

- Recurrent clinically significant deceleration (variable, late or prolonged fetal heart rate decelerations) not responsive to clinical intervention
- Significant bleeding of uterine origin
- New onset of intense uterine pain
- 2 hours without cervical change in the active phase despite adequate labor

Prenatal Management:

- Records of prior delivery reviewed, including type of uterine incision and method of closure. Evaluate history of previous uterine surgery.
    - VBAC may be attempted in some cases where documentation of the previous uterine scar is not available, as long as there is not a high suspicion of a classical uterine incision. (4) (Level B)
    - Patients with a previous classical uterine incision, previous extensive transfundal surgery or prior uterine rupture are not candidates for VBAC. (4) (Level B)
- Appropriate patient education brochure given to patient and reviewed with patient (NNEPQIN sample available).
- Appropriate VBAC consent reviewed during prenatal care and signed (NNEPQIN sample available). Informed consent should include a discussion of the following.
    - A description of the process of risk assessment.
    - The ability of the institution to care for the patient, based on her risk level.
    - The process of transfer of care, should it become necessary based on risk factors.
    - Institutional management plans for uterine rupture.
- Anesthesia consultation/evaluation per institution guidelines.
- If the primary OB provider cannot perform a cesarean section, consultation with provider privileged to perform a cesarean section.

Basic Intra-partum Care Recommendations for all VBAC Patients:

- Review with the patient the risks/benefits of proceeding with VBAC on admission. Determine if the patient's risk level has changed, or patient choice has changed. This review should be documented in the medical record.
- Lab/Blood Bank Preparation

    - Type and Screen, or Type and Cross depending on the institution's blood bank availability in off hours
- Anesthesia personnel notified of admission.
- Pediatric personnel notified of admission.
- OR Team notified of admission and plan in place if cesarean delivery needed.
    - Does not mean an OR is kept open for patients at low risk.
- In Active Labor (4-5 cm dilated).
    - Continuous Electronic Fetal Monitoring.
    - Place 18 gauge IV.
    - Provider on hospital campus who is credentialed to perform a cesarean section.
        - If the primary obstetric provider is not credentialed to perform a cesarean section, the cesarean delivery provider will be consulted.
- All patients attempting VBAC should have their labor progress monitored carefully to ensure adequate progress. Arrest of labor is associated with decreased VBAC success and uterine rupture. Patients with a macrosomic fetus (EFW > 4000 gm), especially those with no previous vaginal birth, are more likely to experience outcomes related to arrest of labor, and require careful monitoring.

Intra-partum Management:
Each hospital should evaluate the resources that they typically have available for the care of laboring women with prior cesarean deliveries. Women should be counseled as to their anticipated risk status and the institutional resources. Cesarean section may be recommended if a woman's risk status increases and provider services cannot be increased and maintained until delivery.

ACOG states: "Respect for patient autonomy supports the concept that patients should be allowed to accept increased levels of risk, however, patients should be clearly informed of such potential increase in risk and management alternatives…In settings where the staff needed for emergency cesarean section are not immediately available, the process for gathering needed staff when emergencies arise should be clear, and all centers should have a plan for managing uterine rupture." (4) (Level C)

Low Risk Patient:
- No additional interventions other than those listed above.
- Cesarean delivery provider may have other acute patient care responsibilities.

Medium Risk Patient:
- Cesarean delivery provider in the hospital during the active phase of labor. Cesarean delivery provider may have other acute patient care responsibilities.
- An open and staffed operating room is available or there is a plan in place if immediate delivery is required. This may be a room where there is adequate lighting, instruments, and general anesthesia can be administered if needed.
- An anesthesia provider is present in the hospital during the active phase of labor.
- Anesthesia staff may have other acute patient care responsibilities.
- There is an established back up protocol for anesthesia services during busy times.

High Risk Patient:
- The cesarean delivery provider is present in the hospital and does not have other acute patient care responsibilities

- Anesthesia staff is present and does not have other acute patient care responsibilities.
- An open and staffed operating room is available.

Caveats:

- Misoprostil is associated with a high rate of uterine rupture and should not be used when a living fetus is still in-utero (4) (Level A). It may be used after delivery for uterine atony.
- There are limited data regarding the safety of a trial of labor in women with more than 2 prior cesarean sections. The degree of increase in risk of uterine rupture is unclear.
- Single layer closure of the uterus with an interlocking chromic type suture has been reported to be associated with an increased risk of uterine rupture. Operative records should be reviewed for the method of closure.
- Transfer during the active phase of labor typically holds little benefit for the patient as access to timely delivery is not present during transport.
- Attempting VBAC with twin gestation carries a similar risk as for those women with singleton pregnancies. Women without other risk factors, who have twins and are candidates for vaginal delivery, may be considered candidates for attempting VBAC. (4) (Level B)
- Women may present to hospitals that have chosen not to offer VBAC services. Transfer to a hospital providing VBAC services necessitates evaluation of the patient, to determine safety, and must comply with federal and state law. Hospitals not offering VBAC services should meet the following standards:
  - Protocol in place for women with prior cesarean sections who present in labor
  - Institution complies with ACOG Guidelines for Prenatal Care and JACHO Standards for Obstetrical Care.
  - Referral and counseling practices established so that women desiring VBAC may be referred to an appropriate center based upon their risk status.
  - Meets NRP Guidelines for infant care.

Proposed Performance Measure:

The percentage of patients for whom there is documented risk status at the time of admission, and documented change in risk status during labor, should that occur.

Complication Rates Associated With VBAC and Planned Cesarean Birth (Includes preterm and term births). (22)

Complication	VBAC Attempt	Planned Cesarean Birth
Uterine Rupture	468/100,000	26/100,000
Maternal Death	4/100,000	13/100,000
Hysterectomy	No significant difference	No significant difference
Blood Transfusion	No significant difference	No significant difference
Maternal Infection	No significant difference	No significant difference
Infant Infection	Insufficient information	Insufficient information
Infant Bag and Mask Ventilation Required	5,400/100,000	2,500/100,000
Transient Tachypnea of the Newborn (TTN)	3,600/100,000	4,200/100,000
Infant with Brain Injury (HIE)	Insufficient information	Insufficient information
Infant death in pregnancy or within 7 of birth (Perinatal Death Rate)	130/100,000	50/100,000
Infant death within 30 days of birth (Neonatal Death Rate)	110/100,000	60/100,000

Guise JM, Denman MA, Emis C, Marshall N, Walker M, Fu R, Janik R, et al. Vaginal birth after cesarean. New insights on maternal and neonatal outcomes. Obstetrics and Gynecology June 2010; 115:1267

References:

1. Grobman WB, Lie, Y, Landon MB, et al: Prediction of uterine rupture associated with attempted vaginal birth after cesarean delivery. Am J Obstet Gynecol July 2008;199:30. (Level II-3)

2. Macones GA, Chahill AD, Stamilo DM, et al: Can uterine rupture in patients attempting vaginal birth after cesarean delivery be predicted? Am J Obstet Gynecol Oct 2006;195:1148. (Level II-3)

3. Landon, MB, Leindecker, S, Spong, CY, et al: The MFMU Cesarean Registry: Factors affecting the success of trial of labor after previous cesarean delivery. Am J Obstet Gynecol Sep 2005;193:1016 (Level II-2)

4. ACOG Practice Bulletin #115, Vaginal Birth After Previous Cesarean Delivery, Obstet Gynecol Aug 2010;116:450

5. Landon MB, Hauth JC, Leveno KJ, et al: For the National Institutes of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal and perinatal outcomes associated with a trial of labor after prior Cesarean delivery. N Engl J Med 351:2581-2589, 2004 (Level II-2)

6. Grobman WA, Gilbert S, Landon MB, et al: Outcomes of induction of labor after one prior Cesarean. Obstet Gynecol 109:262-269, 2007 (Level II-2)

7. Cahill AG, Waterman BM, Stamilio DM, et al: Higher maximum doses of oxytocin are associated with an unacceptably high risk for uterine rupture in patients attempting vaginal birth after Cesarean delivery. Am J Obstet Gynecol 199:32.e1-32.e5, 2008 (Level II-2)

8. Health and Human Development Maternal-Fetal Medicine Units Network. The MFMU Cesarean registry: Risk of uterine rupture with a trial of labor in women with multiple and single prior Cesarean delivery. Obstet Gynecol 108:12-20, 2006 (Level II-2)

9. Leung AS, Farmer RM, Leung EK, et al: Risk factors associated with uterine rupture during trial of labor after Cesarean delivery: A case controlled study. Am J Obstet Gynecol 168:1358, 1993 (Level II-2)

10. Mark B. Landon, MD: Predicting Uterine Rupture in Women Undergoing Trial of Labor After Prior Cesarean Delivery. Semin Perinatol 34:267, 2010 (Level III)

11. Elkousy, MA, Mary Sammel, ScD, Erika Stevens, MA, et al: The effect of birth weight on vaginal birth after cesarean delivery success rates. Am J Obstet Gynecol 2003;188:824 (Level II-2)

12. Nicole Jastrow, MD, Stephanie Roberge, Robert J. Gauthier, MD, et al: Effect of Birth Weight on Adverse Obstetric Outcomes in Vaginal Birth After Cesarean Delivery. Obstet Gynecol 2010;115:338 (Level II-2)

13. Carolyn M. Zelop, MD, Thomas D. Shipp, MD, John T. Repke, MD, et al: Outcomes of trial of labor following previous cesarean delivery among women with fetuses weighing >4000 g. Am J Obstet Gynecol 2001;185: 903 (Level II-2)

14. Usha Kiran TS, et al: Is gestational age an independent variable affecting uterine scar rupture rates? Eur J Obstet Gynec Reprod Biol 2006;126:68 (Level II-2)

15. Hammoud A, Hendler I, Gauthier RJ, et al: The effect of gestational age on trial of labor after cesarean section. J Mat Fet Neo Med 2004;15:202 (Level II-2)

16. Shipp TD, Zelop CM, Repke JT, et al: Interdelivery interval and risk of symptomatic uterine rupture. Obstet Gynecol 97:175-177, 2001 (Level II-2)

17. Stamilio D, DeFranco E, Para E, et al: Short interpregnancy interval: Risk of uterine rupture and complications of vaginal birth after Cesarean delivery. Obstet Gynecol 110:1075-1082, 2007 (Level II-2)

18. Bujold E, Mehta SH, Bujold C, et al: Interdelivery interval and uterine rupture. Am J Obstet Gynecol 187:1199-1202, 2002 (Level II-2)

19. Bujold, E, Goyet, M, Marcoux, S, et al: The Role of Uterine Closure in the Risk of Uterine Rupture. Obstet. Gynecol. 2010;116:43. (Level II-2)

20. Bujold E, Bujold C, Hamilton, EF, et al: The impact of a single-layer or double-layer closure on uterine rupture. Am J Obstet Gynecol 2002;186:1326 (Level II-2)

21. Hibbard, JU, Gilbert, S, Landon, MB, et al: Trial of Labor or Repeat Cesarean Delivery in Women With Morbid Obesity and Previous Cesarean Delivery. Obstet Gynecol 2006;108:125. (Level II-2)

22. Guise JM, Denman MA, Emis C, Marshall N, Walker M, Fu R, Janik R, et al. Vaginal birth after cesarean. New insights on maternal and neonatal outcomes. Obstet Gynecol 2010; 115:1267

23. Macones, GA, Cahill A, et al: Obstetric outcomes in women with two prior cesarean deliveries: Is vaginal birth after cesarean delivery a viable option? Am J Obstet Gynecol 2005; 192: 1223 (Level II-B)

24. Tasheen F, Griffiths M: Vaginal birth after two caesarean sections (VBAC-2)—a systematic review with meta-analysis of success rate and adverse outcomes of VBAC-2 versus VBAC-1 and repeat (third) caesarean sections. BJOG 2010;117:5–19 (Level II-B)

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventative Services Task Force

I Evidence obtained from at least one properly designed randomized controlled trial.

II–1 Evidence obtained from well–designed controlled trials without randomization.

II–2 Evidence obtained from well–designed cohort or case–control analytic studies, preferably from more than one center or research group.

II–3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6503
603-271-4225 1-800-852-3345 Ext. 4225
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NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Jeffrey A. Meyers
Commissioner

Marcella Jordan Bobinsky
Acting Director

REFUSAL TO CONSENT TO REPEAT NEWBORN SCREENING

Name of Infant	Birth Date
Street Address	Hospital of Birth
City/State/Zip	Medical Record Number

I understand that the initial specimen was unsatisfactory for testing or indicated a need to repeat the screening.

I understand that State Law requires Newborn Screening for all infants born in New Hampshire.

I understand that the screening is done for the early detection of treatable disorders and that symptoms sometimes do not appear for several weeks or months.

I understand that if undetected and untreated these disorders can cause permanent damage to my child, including serious mental retardation, growth failure and, in some cases, death.

The benefits of newborn screening and the potential danger of not being screened have been explained to me. My decision to refuse the repeat testing was made freely without force or encouragement by my doctor, my baby's doctor, hospital personnel or State officials.

Signed	Relationship to Infant
Witnessed by	Date

Original copy to Infant's Medical Record
Copies: Parent, Practitioner, And State Screening Program 2012

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6503
603-271-1037 1-800-852-3345 Ext. 1037
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NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Jeffery A. Meyers
Commissioner

Lisa M. Morris
Director

NEWBORN HEARING SCREENING RESULTS: home/center births

Birth Facility_____

Infant_____ DOB_____

Race_____ Gender_____ Parent _____ Street

Address_____

City & Zip Code_____ Phone_____

Infant's health care provider_____

NHS Results	Technology	Right Ear	Left Ear
1st Screen Date:	OAE	☐ Pass ☐ Refer ☐ Not screened	☐ Pass ☐ Refer ☐ Not screened
Rescreen Date:	OAE	☐ Pass ☐ Refer ☐ Not screened	☐ Pass ☐ Refer ☐ Not screened

Reason not screened: ☐ deceased ☐ equipment broken ☐ parent declined ☐ transferred to facility:_____

Recommendations for rescreen refers:

- ☐ Family declines to follow-up
- ☐ Family to schedule diagnostic audiology appointment
- ☐ Our facility sent a fax referral:

  Testing Center_____

  Date fax was sent_____
- ☐ Our facility scheduled the diagnostic audiology appointment:

  Testing Center_____

  Date of appointment_____

Risk Factors (only if checked):

- ☐ Craniofacial anomaly or ear tags/ear pits
- ☐ Family history of permanent hearing loss
- ☐ Head trauma
- ☐ In utero/congenital infection
- ☐ Neurodegenerative disorder
- ☐ Syndrome associated with hearing loss
- ☐ Postnatal infection (e.g. Meningitis)
- ☐ Physical findings associated with hearing loss (i.e. white forelock)

NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

Patient Education: Birth Choices After a Cesarean Section

[YOUR PRACTICE NAME]

This document was created by obstetric doctors, midwives, and nurses from hospitals across Northern New England. It is based upon thorough and thoughtful review of medical studies on vaginal birth after cesarean section (VBAC). It is a collection of everyone's understanding of these studies. Our goal is to give you a fair review of the risks and benefits of attempting vaginal delivery after a cesarean delivery. We believe vaginal birth after a cesarean section is a good choice for many women.

[YOUR PRACTICE] wants to give you the best care possible. Taking part in choices about your delivery is an important part of this care. Because you had a cesarean birth before, you come to this delivery experience with further choices to make. We will give you information so that you can make choices that are best for you and your family. The goal is a healthy mother and baby, whether the birth is vaginal or cesarean.

VBAC means Vaginal Birth After Cesarean Section.

What are the benefits of VBAC compared to a planned cesarean birth?

- Faster time to heal after birth
- Shorter hospital stay
- Less risk of infection after delivery
- No chance of problems caused by surgery (infection, injury to bowel or urinary tract, or blood loss)
- Less risk that the baby will have breathing problems
- Quicker return to normal activities because there is no pain from surgery.
- Greater chance of having a vaginal birth in later pregnancies
- Less risk of problems with how the placenta attaches in future pregnancies.

Can all women with previous cesarean birth attempt VBAC?

Some women should not try VBAC. If the cesarean scar is in the upper part of the uterus, where contractions occur, the risk of the uterus tearing (also called uterine rupture) is high. These women should have repeat cesarean births and avoid labor. Women with a scar in the lower part of the uterus have a lower risk of the uterus tearing and VBAC is considered safe. The type of scar you have in your skin may not be the same type of scar you have in your uterus. Your doctor or midwife will review the records of your previous birth to find the location of your uterine scar. If you have had three or more cesarean births and no vaginal births, the risk of the uterus tearing during labor may increase and VBAC may not be recommended. Your doctor or midwife will review these risks with you.

What are the risks of VBAC?

- A tear or opening in the uterus (womb) occurs in 5 to 10 women out of every 1,000 low risk women who try VBAC (0.5% to 1.0%).
  - Risks to the mother if there is a tear in the uterus include:
    - Blood loss that may need transfusion
    - Damage to the uterus that may need hysterectomy (removal of the uterus)
    - Damage to the bladder
    - Infection
    - Blood clots
    - Death, which is very rare.
  - Risks to the baby if there is a tear of the uterus are brain damage and death. Not all tears in the uterus harm the baby. About 7% of the time the baby is harmed when the uterus tears. In other words, 5 to 10 babies out of every 10,000 VBAC tries will suffer brain damage or death (0.05% to 0.1%) due to uterine rupture.
- The normal risks of having a vaginal birth are also present for VBAC.
- The risk of your uterus tearing during labor is increased with any of the following:
  - Labor that is induced (does not start on its own)
  - More than 1 cesarean section
  - Less than 18 months since your last cesarean delivery
  - Need for medicine during labor to increase contractions
- If a vaginal birth cannot occur, then a cesarean birth must be done. Overall, 70-80% of attempted VBAC are successful. A cesarean section after attempting vaginal delivery has the same types of risks as a planned cesarean delivery. However, the risk of infection, transfusion, blood clots and needing hysterectomy is increased.

How can I reduce risks to my baby and me?

- Regular prenatal care is very important in reducing all risks in pregnancy.
- Having labor occur naturally, rather than using medications to start labor, brings down the risk of a tear in the uterus. Your doctor or midwife will talk to you about this, taking into account your own situation.
- Having at least 18 months time between the date of your last cesarean birth and the due date of this pregnancy helps insure the strength of the uterus during this pregnancy.

What are the risks of a planned cesarean birth, if that is my choice?

- The risk that the uterus will tear before a planned cesarean birth is very low. Because you have a scar on your uterus from your prior cesarean birth, you will always be at risk for having a tear in your uterus. The tears usually occur during labor. The risks to the baby and you are the same as if the uterus tore during a VBAC.
- Blood loss
- More scars developing on the uterus
- Infection
- Scarring inside the abdomen
- Injury to organs inside the body

- Problems with anesthesia
- Blood clots
- Risk in later pregnancies of problems with the placenta
- Death, which is very rare

If I choose a repeat cesarean birth, what can I expect in my recovery?
Each woman has her own special experience with cesarean delivery and recovery. Many women talk about their recovery from their second cesarean as easier than their recovery from their first cesarean. This may be due to knowing what to expect in a second cesarean and feeling less tired because you did not have labor. Still, recovering from any type of childbirth takes time.

Overall, how do the risks of VBAC compare to repeat cesarean birth without labor?

- The risk of the uterus tearing during a low risk VBAC is 5 in 1,000 (0.5%). Because you have a scar on your uterus from your prior cesarean birth, you will always be at risk for having a tear in your uterus. The tears usually occur during labor. The risk that the uterus will tear before a planned cesarean birth is very low. The risks to the baby and you are the same as if the uterus tore during a VBAC.
- Overall, the risk of blood transfusion, hysterectomy, blood clots and infection are increased in women who attempt vaginal delivery. These increased risks are from the women who are not successful in vaginal delivery.
- The risk of your baby dying or being seriously injured during VBAC is the same as during a first labor. There is a higher risk of the baby dying or being injured with VBAC compared to a planned repeat cesarean birth. The overall risk with VBAC is about 11 out of 10,000 (0.1%) and with a planned repeat cesarean birth 6 out of 10,000 (0.06%).

There is a table at the end of this paper that shows these risks.

What is the chance that trying a VBAC will result in a vaginal birth?

- 60%-80% of women who try a VBAC have a vaginal birth. There is no perfect way to say who will deliver vaginally. A number of factors increase the chance of success. However, even if none of these factors are present, the chance of vaginal delivery is at least 50%. Factors that predict success are:
  - Cesarean birth for a reason that is not likely to happen again (i.e. breech presentation)
  - Having a vaginal birth in the past
  - Labor that occurs naturally
  - The length of the pregnancy is less than 40 weeks
  - A cervix that is at least 2 cm dilated and very thin when admitted to the hospital

How do women make a choice about a VBAC?

- Having a vaginal birth is very important to some women. For many women, the benefits of trying a vaginal birth outweigh the risks. Women who deliver vaginally have less postpartum discomfort, shorter hospital stays, and describe a feeling of wellness sooner than women recovering from cesarean section.
- Other women choose cesarean birth because they do not want to go through labor. They may be more concerned about the risk of the uterus tearing and the risks of vaginal delivery than the risks of cesarean birth.

- There may be added benefits and risks, some of them emotional, with either choice. We want you to discuss these with your provider and family.
- **Future Child Bearing:** If a woman is very certain in her desire to have no more children, then the VBAC benefit of less uterine scarring and a better place for the placenta to attach is not present and a repeat cesarean section may be best. However, if there is even a small chance of another pregnancy, a low risk VBAC may be the better choice.
- The purpose of this pamphlet is to help you make the choice that is best for YOU.

If I select VBAC, what can I expect during prenatal care and at the hospital?

- You will be asked to sign a consent form showing that you understand the risks and benefits of your choice. The form will ask you to give your choice.
- Your doctor or midwife will talk with you when to call or come in for labor.
- You may meet with an anesthesiologist before your labor.
- Constant fetal heart rate and contraction monitoring during active labor (when your cervix is 4-5 cm dilated).
- You will have an IV so that fluids and medications may be given to you if needed.
- Blood samples will be taken.
- You options for pain medication during labor are not affected by your prior cesarean section.
- A doctor able to perform a cesarean birth will be on the hospital grounds during the active phase of labor.

What is my hospital's experience with VBAC?

[YOUR PRACTICE] has been performing VBAC since [DATE]. In Northern New England, 60-80% of women who try VBAC have a vaginal birth. Your hospital of choice has anesthesia staff, a doctor for the baby and operating room services available 24 hours per day. Your risk of a tear in the uterus and how far along you are in labor determine if all these people are present in the hospital. In cases of tear in the uterus, injury to the baby may occur. The risk of injury to the baby increases with the time it takes to deliver the baby and the damage to the placenta. We have specific plans to respond once a problem is detected. However, there is risk associated with every pregnancy. Risk can never be completely removed. We share the same goal as you: a healthy baby delivered to a healthy mom. We will make every effort to ensure this.

You also have the choice of having your birth at a hospital where anesthesia, operating room staff and doctors for the baby are always present in the hospital. This may lower the risk to the baby if there is a tear in the uterus, but not in all cases. However, delivery at another hospital may mean travel during labor and having your baby away from your local community and support system. You may want to talk to your doctor or midwife about the risks and benefits of planning to deliver at such a hospital. Changing care from one hospital to another during labor may be of little benefit and may increase the risk of harm to you and your baby.

What if I change my mind?

If during the VBAC process you have questions about continuing, we encourage you to talk with your doctor or midwife. You may change your mind about VBAC. However, if delivery is about to happen, a cesarean section may not be possible.

Am I comfortable with making the decision?
Each woman's decision is personal. Your doctor or midwife is your best source of information. She or he will guide you and your family in deciding how you have your baby. The overall goal is a healthy mother and baby, whether the delivery is by vaginal or cesarean birth.

Complication Rates Associated With VBAC and Planned Cesarean Birth (Includes Preterm and Term Births).

Complication	VBAC Attempt	Planned Cesarean Birth
Uterine Rupture	468/100,000 (0.5%)	26/100,000 (0.026%)
Maternal Death	4/100,000 (.004%)	13/100,000 (0.013%)
Hysterectomy	No significant difference	No significant difference
Blood Transfusion	No significant difference	No significant difference
Maternal Infection	No significant difference	No significant difference
Infant Infection	Insufficient information	Insufficient information
Infant breathing problems requiring immediate interventions	5,400/100,000 (5.4%)	2,500/100,000 (2.5%)
Infant breathing problems which last 6-48 hours	3,600/100,000 (3.6%)	4,200/100,000 (4.2%)
Infant with Brain Injury	Insufficient information	Insufficient information
Fetal/Infant Death during pregnancy or the first 7 days after birth	130/100,000 (0.13%)	50/100,000 (0.05%)
Infant death within 30 days of birth	110/100,000 (0.11%)	60/100,000 (0.06%)

Guise JM, Denman MA, Emis C, Marshall N, Walker M, Fu R, Janik R, et al. Vaginal birth after cesarean. New insights on maternal and neonatal outcomes. Obstetrics and Gynecology June 2010; 115:1267

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6503
603-271-4225 1-800-852-3345 Ext. 4225
Fax: 603-271-4519 TDD Access: 1-800-735-2964

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Jeffrey A. Meyers
Commissioner

Lisa Morris
Director

NEWBORN SCREENING REFUSAL FORM

Name of Infant	Birth Date
Street Address	Hospital of Birth
City/State/Zip	Medical Record Number

I understand that State Law requires Newborn Screening for all infants born in New Hampshire.

I understand that the screening is done for the early detection of treatable disorders and that symptoms sometimes do not appear for several weeks or months.

I understand that if undetected and untreated these disorders can cause permanent damage to my child, including serious mental retardation, growth failure and, in some cases, death.

The benefits of newborn screening and the potential danger of not being screened have been explained to me. My decision to refuse the testing was made freely without force or encouragement by my doctor, my baby's doctor, hospital personnel or State officials.

Signed	Relationship to Infant
Witnessed by	Date

Original copy to Infant's Medical Record
Copies: Parent, Practitioner, And State Screening Program
2009

NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

Consent for Birth After Cesarean Section

After cesarean section, a woman may choose to have a planned cesarean birth or choose a trial of labor for vaginal birth. It is likely that 60-80% of women who try a vaginal birth after cesarean section (VBAC) will be successful. We want you to understand the benefits and risks of your choices. There is risk that goes along with every pregnancy. We share the same goal as you: a healthy baby delivered to a healthy mom. We will make every effort to ensure this.

VBAC means Vaginal Birth After Cesarean Section.

What are the benefits of VBAC compared to a planned cesarean birth?

- Faster time to heal after birth
- Shorter hospital stay
- Less risk of infection after delivery
- No chance of problems caused by surgery (infection, injury to bowel or urinary tract, or blood loss)
- Less risk that the baby will have breathing problems
- Quicker return to normal activities because there is no pain from surgery.
- Greater chance of having a vaginal birth in later pregnancies
- Less risk of problems with how the placenta attaches in future pregnancies.

What are the risks of VBAC?

- A tear or opening in the uterus (womb) occurs in 5 to 10 women out of every 1,000 low risk women who try VBAC (0.5% to 1.0%).
  - Risks to the mother if there is a tear in the uterus include:
    - Blood loss that may need transfusion
    - Damage to the uterus that may need hysterectomy (removal of the uterus)
    - Damage to the bladder
    - Infection
    - Blood clots
    - Death, which is very rare.
  - Risks to the baby if there is a tear of the uterus are brain damage and death. Not all tears in the uterus harm the baby. About 7% of the time the baby is harmed when the uterus tears. In other words, 5 to 10 babies out of every 10,000 VBAC tries will suffer brain damage or death (0.05% to 0.1%) due to uterine rupture.
- The normal risks of having a vaginal birth are also present for VBAC.
- The risk of your uterus tearing during labor is increased with any of the following:
  - Labor that is induced (does not start on its own)
  - More than 1 cesarean section

- Less than 18 months since your last cesarean delivery
- Need for medicine during labor to increase contractions

- If a vaginal birth cannot occur, then a cesarean birth must be done. Overall, 60-80% of attempted VBAC are successful. If a cesarean section is necessary after attempting vaginal delivery, there are the same types of risks as a planned cesarean delivery *and additional risks* including higher chances of infection, transfusion, blood clots and potential hysterectomy.

What are the risks of a planned cesarean birth, if that is my choice?

- The risk that the uterus will tear before a planned cesarean birth is very low. Because you have a scar on your uterus from your prior cesarean birth, you will always be at risk for having a tear in your uterus. The tears usually occur during labor. The risks to the baby and you are the same as if the uterus tore during a VBAC.
- Blood loss
- More scars developing on the uterus
- Infection
- Scarring inside the abdomen
- Injury to organs inside the body
- Problems with anesthesia
- Blood clots
- Risk in later pregnancies of problems with the placenta
- Death, which is very rare

I understand that [YOUR PRACTICE] is not a hospital and does not have anesthesia staff, a doctor for the baby and operating room services available 24 hours a day. The risk of a tear in the uterus and how far along labor has gone will be used to decide if all of these people are present in the hospital. In cases of a tear in the uterus, injury to the baby may occur. The risk of injury to the baby increases with the time it takes to deliver the baby and the damage to the placenta. [YOUR PRACTICE] has specific plans to respond once a problem is detected. However, there is risk associated with every pregnancy. Risk can never be completely removed.

I also can decide to have the baby at a hospital where anesthesia, operating room staff, and a doctor for the baby are always there in the hospital. This may lower the risk to the baby if there is a tear in the uterus, but not in all cases. Delivery at another hospital may mean travel during labor and having my baby away from my local community and support system. Changing care from one hospital to another during labor may be of little benefit and may increase the risk of a bad outcome for you and your baby.

Please initial on the lines and then sign below.

_____I have read this consent form. I understand the benefits and risks with a planned cesarean section and VBAC. I understand how these benefits and risks apply to me.

_____I have had the chance to read the VBAC patient education material and ask questions. My questions were answered to my satisfaction.

_____I understand and accept the labor and delivery services homebirth has to offer.

_____If I choose a VBAC, this consent will be reviewed as needed during the labor. I may want to ask for a repeat cesarean section or my doctor may find a need to deliver my baby by cesarean section.

_____ I have chosen to try a VBAC for delivery of my baby.

_____ I have chosen to try a VBAC if I go into labor prior to my planned cesarean section.

_____ I have chosen a planned cesarean section.

Signature of Patient:_____Date:_____

Signature of Provider:_____Date: _____

Signature of Witness:_____Date: _____

ST ATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6503
603-271-4225 1-800-852-3345 Ext. 4225
Fax: 603-271-4519 TDD Access: 1-800-735-2964

NH DIVISION OF
Public Health Services
lmp,'0Yinghe81lh. preventingdi5casc,reducing cosis forafl

Nicholas A. Toumpas
Commissioner

Jose **Thier Montero**
Director

PULSE OXII\'IETRY REPORT

Date of screening:_____ Age in hours at first measurement: _____

Reason for Report: (all that apply)

_ Baby failed the pulse oximetry screening. Not screened

Birth Attendant Signature:_____

Print name: _

Birth Place Address: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ **New Hampshire**

Baby's Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ DOB:_____

Mother's Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ DOB:_____

PULSE OXIMETRY RESULTS

____Pass Failed

I st Measurement: Time: ____ Right Hand _ % Foot %

2nd Measurement: Time: ____ Right Hand _ % Foot %

3rd Measurement: Time: _ _ _ Right Hand _ % Foot %

Health Care Provider that failed screening was reported to:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Tel#_ _ _ _ _ _ _ _ _ _ _

Was baby transferred to another facility because of screening?____ Yes No

Where? _

Not screened If **not screened, what was the reason(** all that apply)

_ Baby expired Parents refused Other

Please send completed form to: Division of Public Health Services
NH Newborn Screening Program
29 Hazen Drive
Concord, NH 03301