OKLAHOMA MIDWIFE TWINS INFORMED CONSENT FORM

Instructions: Per OAC 310:395-5-6.1(a)(1). Informed consent and disclosure statements on vaginal birth after caesarian (VBAC), vaginal breech birth, and vaginal multiple birth must be approved by the Advisory Committee on Midwifery. Copies of this consent form may be downloaded by visiting the OSDH Midwives Program webpage or requesting a copy by contacting the OSDH Consumer Health Service at CHSLicensing@health.ok.gov.

TWINS INFORMED CHOICE AND CONSENT AGREEMENT

The American College of Obstetricians and Gynecologists considers twin birth an absolute contraindication to planned out-of-hospital birth. This is due to a higher risk of perinatal and maternal death.

When you are pregnant with twins, you have three (3) options for delivery:

- 1. A planned vaginal hospital birth as determined by a physician.
- 2. A planned elective cesarean birth.
- 3. A planned home birth with risks as described below.

I, _______, do hereby request the assistance of a Licensed Midwife, in the birth of our babies outside of a hospital. I make this request with a full understanding of the potential risks and potential complications of a twin birth. These complications and risks may include, but are not limited to:

- Maternal hemorrhage
- Increased risk of blood transfusion or hysterectomy
- Increased risk of maternal death from hemorrhage
- Increased risk of fetal distress in one or both babies
- Increased risk of fetal/neonatal damage due to oxygen deprivation
- Increased risk of fetal or neonatal death
- Cord prolapse (where the cord presents before the baby through a dilated cervix), which could interrupt the flow of oxygen to the baby resulting in brain damage and/or death
- If Baby B is breech and larger than Baby A (20% discordance), then planned vaginal delivery of Baby B is not recommended and is unsafe for home birth

Breech section related to Twin B- In the event that Baby B is breech, becomes breech, or presentation is unknown, complications and risks may include, but are not limited to:

- Increased need for resuscitation of the newborn
- Overall, vaginal delivery of a breech baby may increase the risk of fetal death and/or short-term serious neonatal morbidity
- These risks may be higher in first time mothers
- The distance from a NICU and pediatrician may increase risk of morbidity and mortality to the infant
- Perineal lacerations, episiotomy (injury to the area between the vagina and the anus, surgical cut to the area between the vagina and the anus)
- Fetal head entrapment at delivery
- Increased need for resuscitation of the newborn

I understand that my provider, with o	ollaboration of Maternal Fetal Medicine (MFM), will be better able to counsel me
on the risks of a delivery and confirm	that Baby A is head down if I have an ultrasound at 34-36 weeks to check the size
and position of the babies	(initial)

I agree to undergo a diagnostic ultrasound in order to stay in midwifery care . ____ (initial)

I understand that the average gestational age for delivery of twins is 35 weeks gestational age, that I have a higher risk of preterm labor, preeclampsia, and gestational diabetes, therefore my risk of being unable to deliver at home is elevated.

OKLAHOMA MIDWIFE TWINS INFORMED CONSENT FORM (Continued)

If transport is over 20 minutes, increased distance to surgical interventions, NICU, and pediatric services may increase risk of infant and maternal death. The place of birth is/is not within twenty (20) minutes of transport to the nearest hospital with twenty-four (24) hour obstetrical and anesthesia services available. I further understand that though I prefer to give birth vaginally outside of a hospital that this may not be possible. I agree to abide by the professional judgment and decisions made by my midwife as to the medical necessity for transport to a hospital. I also understand that if at any point in my labor I wish to be transported; I will be transferred at once. I attest that I have had ample opportunity to ask questions and that these questions have been answered to my satisfaction. (initial) The client meets the criteria for Twin birth listed in OAC 395 5-6.1. ____ (Midwife initial and date) All applicable consent forms (i.e. VBAC, Breech) have been completed and signed. (Midwife initial and date) CLIENT ACKNOWLEDGEMENTS Initials Client must read each item and initial each in the space provided below. 1. I understand that transfer to a hospital for further evaluation of possible birth injuries to myself or newborns may be) necessary. 2. Transfer of care can be initiated at any time at the discretion of the midwife or the client. 3. I understand that Baby A must be head down at term, or I will be transferred out of midwifery care. 4. I have been informed that my midwife's experience of Twin births is:) Number of attended Twin births) Number of performed Twin births) Continuing Education hours in Twin births 5. I understand the importance of promptly notifying my midwife of labor symptoms. 6. My midwife has offered me the option of a second opinion. 7. My midwife has referred me to MFM for a consultation per 395-5-6.1(e)(3) 8. I understand that during the course of care, it may be necessary or appropriate to perform additional testing and procedures outside the standard of care, for which informed consent will be offered at that time. After careful consideration of the above information: I am choosing a Twin birth under the care of my midwife. I am choosing to transfer care to a hospital provider. **REFERENCES** 1."Multifetal Gestations: Twin, Triplet, and Higher-Order Multifetal Pregnancies" 2. "Practice Bulletin" PB Number 169, October 2016. ACOG. 3. "Planned Home Birth" Committee Opinion CO Number 697. April 2017. ACOG. READ CAREFULLY By my signature below I give full, informed consent to an out-of-hospital twin birth. The risks, benefits, and alternatives have been discussed and all questions have been answered. Mother/Client: Signature I have provided the information above to the Client. Midwife: Print Name / Lic. No. Signature