

APPENDIX D

About Your Care During Labor and Birth

Having a baby is natural. Most birthing people and babies go through it without serious problems. Even so, some situations may arise near the end of your pregnancy, or during labor. These can affect the care you or your baby may need.

Many of those situations are described below. Some common practices you might experience at the hospital are also described. Ask your doctor, midwife, or nurse if you have questions.

LABOR

1. A nurse will work with your doctor or midwife to take care of you. In some hospitals, doctors who are in training (residents) may also help care for you.
2. Other trainees may be involved in caring for you. Students are always supervised by your doctor, midwife, or a nurse.
3. You may have a blood test during labor.
4. A nurse may put a monitor on your belly to check your baby's heartbeat. If it is normal, the monitor may be removed. The baby's heartbeat will be checked again during your labor.
5. If your baby's heartbeat needs to be checked more closely, you might wear a monitor for longer. This monitor may be placed on your skin, or sometimes it is placed on top of the baby's head. Sometimes the baby's heartbeat patterns cause concern, even when the baby is fine. These patterns can be hard to understand. Your chance of a cesarean or vaginal delivery with vacuum or forceps increases when your baby's pattern raises a concern. Checking your baby's heartbeat does not prevent cerebral palsy or birth defects.
6. Sometimes it is possible to change the baby's heartbeat pattern. Your doctor or midwife can place a tube inside your womb and add fluid around the baby. This added fluid may take pressure off the umbilical cord during your labor.
7. You may have an intravenous line (IV) in your arm during labor. This is used to give you extra fluids, pain relief drugs, or antibiotics.
8. Pain you feel during labor can be relieved many ways. You might choose walking, a bath or shower, breathing, massage, special pillows, or a combination. Your doctor or midwife can offer you other, safe choices:

Medication: You get pain relief medication by needle (a “shot”) or through an IV line. You may get sleepy. Allergic reactions are rare.

Epidural: A doctor places a thin tube in your back. This takes about 20 minutes. You can then get drugs through the tube that will relieve most of your labor pain.

Nitrous oxide: Where available.

9. If your labor slows down, your doctor or midwife might give you oxytocin through an IV to make your contractions stronger and closer together.
10. Your doctor or midwife may try to help you start (induce) labor. Some reasons for this are:
 - your baby is overdue by more than a week or two,
 - your baby has not grown well,
 - infection,
 - high blood pressure,
 - diabetes, or
 - your water breaks.

If your cervix is soft and stretchy, you may be given oxytocin through an IV. If your cervix is not ready, you may get a prostaglandin medication, or a special balloon inserted, to soften the cervix before using oxytocin.
11. Sometimes, your labor may be induced for non-medical reasons before your due date. Generally, this cannot be done before 39 weeks gestation because babies who deliver before then can have trouble breathing room air.
12. The risks of inducing labor include creating contractions that are too strong or frequent. This can cause changes in the baby's heart rate. This risk is usually manageable and the contractions can be decreased. It is best to speak with your own provider regarding advice for induction; each hospital or institution will have its own rules regarding the scheduling of inductions.

APPENDIX D: ABOUT YOUR CARE DURING LABOR AND BIRTH

VAGINAL BIRTH

1. Labor contractions slowly open your cervix. When your cervix is completely open, contractions, along with your help, push the baby through the birth canal (vagina). Usually, the baby's head comes out first, then the shoulders.
2. About 10–15 percent of birthing people need some help getting the baby through the birth canal. A doctor or midwife may apply a special vacuum cup or forceps (tongs) to your baby's head. The doctor will then pull while you push the baby out.
3. In approximately one percent of births, the shoulders do not come out easily. This is called shoulder dystocia. If this happens, your doctor or midwife will try to free the baby's shoulders. Shoulder dystocia may cause a broken bone or nerve damage to the baby's arm. Most often, these problems heal quickly. Shoulder dystocia may cause tears around your vaginal opening, and bleeding after birth.
4. Many birthing people get small tears around their vaginal opening. Sometimes a doctor or midwife will cut some vaginal tissue to make the opening bigger. This is called an episiotomy.
5. Most birthing people with tears or an episiotomy will need stitches. Your stitches will dissolve over a few weeks during healing. The area may be swollen and sore for a few days. Rarely, infection may occur. Infrequently, a tear or cut may extend to the rectum. Most often this heals with no problem.
6. Normally, the placenta will come out soon after birth. If not, then the doctor or midwife must reach into the womb and remove the placenta. You may need anesthesia, medicine that takes away pain and might make you sleepy.
7. Everyone loses some blood during childbirth. Some reasons you might lose a lot are listed.
 - The placenta doesn't pass on its own,
 - You are having more than one baby, such as twins or triplets.
 - Your labor lasts a very long time.

8. Oxytocin in a shot or IV can help reduce bleeding after birth. If your bleeding is very heavy, you may be given other medications to help contract your uterus. Very few people need a blood transfusion after vaginal birth.

CESAREAN (ABDOMINAL) DELIVERY

1. About one third of births are by cesarean. Some are planned; some are not.
2. During cesarean birth, a doctor delivers the baby through an incision (cut) in your abdomen (belly).
3. Here are some common reasons you might need an abdominal birth:
 - Your cervix doesn't open completely,
 - Your baby doesn't move down the birth canal,
 - Your baby needs to be delivered quickly because of a problem for you or the baby,
 - Your baby is not in a position that allows for a vaginal delivery, or
 - You gave birth by cesarean delivery before.
4. Anesthesia is always used for a cesarean. Most cesareans are performed using regional anesthesia (spinal, epidural, or combined spinal-epidural) so that the birthing person is awake during the delivery. Some are performed using general anesthesia and the birthing person is not awake during the delivery.
5. You will lose more blood during a cesarean birth than during a vaginal birth. About 12 out of 1,000 birthing people who have cesareans need a blood transfusion.
6. Infection is more common after an abdominal birth. Your doctors will give you medication to help prevent infection.
7. A thin tube (catheter) will drain your bladder during a cesarean. It may remain in place for 12–24 hours afterwards.
8. In less than one percent of cesareans, the birthing person's bowel or urinary system is injured. Most of the time these problems are fixed during the surgery.
9. In less than one percent of cesareans, the baby might be injured. Such injuries are usually minor.

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AFTER BIRTH

1. Infection of the uterus (womb)
 - After a vaginal birth = 2–3 percent
 - After a cesarean birth = 5–15 percent.
 - Drugs (antibiotics) can lower the risk, but don't guarantee you won't get an infection.
2. You will have cramps as your womb returns to its normal size. Cramping gets stronger with each birth. You may notice it more when breastfeeding.
3. After a vaginal birth, you will probably have discomfort around your vaginal opening. After a cesarean birth, you will have pain from the incision. Ask your doctor or midwife for pain relief.
4. Vaginal bleeding is normal after birth. It will lessen over 1–2 weeks. About one percent of birthing people will need treatment for heavy bleeding. Sometimes, heavy bleeding can happen weeks after birth.
5. Most people feel tired and may feel sad after birth. For about 10 percent of new birthing people, these feelings of sadness linger or get worse. This may be postpartum depression. If this happens, ask your doctor or midwife for help.
6. When you can leave the hospital will depend on your health, your baby's health, and the help you have at home.

NEWBORN

1. At one minute, and again at five minutes after birth, your baby will be given Apgar scores. The scores are based on heart rate, breathing, skin and muscle tone, and vigor. Apgar scores help your pediatrician and the hospital staff care for your baby.
2. About 3 to 4 percent of babies are born with birth defects. Many (for example, extra fingers or toes) do not hurt the baby. Some, such as some heart abnormalities, can be serious.
3. Approximately 7 to 10 percent of babies are born prematurely, that is before 37 completed weeks of pregnancy. Premature babies may require treatment in a special nursery or an intensive care unit. Some babies born after 37 weeks also may need special care.
4. About 12 to 16 percent of babies pass meconium (the first bowel movement) into the amniotic fluid before delivery. If your baby is born with meconium-stained fluid, and is not crying at birth, the pediatrician will suction the meconium from the nose and mouth.
5. After birth, your baby will be given eye ointment to prevent eye infections. Your baby will also get a Vitamin K shot to prevent bleeding. A few drops of blood from one heel are taken to screen your baby for some diseases. The results are sent to your pediatrician. Your baby's hearing will be checked while in the hospital. Your baby will get the first shot to prevent hepatitis B before going home.
6. Three to four of every 1,000 newborns have serious infections of their blood, lungs, and—in more rare cases—the brain and spine. You may be given antibiotics to protect your baby if:
 - you carry Group B Strep,
 - you had a previous baby who had a Group B Strep infection shortly after birth,
 - you develop a fever during labor, or
 - your membranes (bag of waters) are ruptured for a long time.
7. If your baby is at risk, your pediatrician may order testing for infection. Your baby may also receive drugs to prevent infection.

APPENDIX D: ABOUT YOUR CARE DURING LABOR AND BIRTH

INFREQUENT OR RARE EVENTS

The following problems occur infrequently or rarely during pregnancy:

1. A baby is born too early to survive, or with serious medical problems. A baby may die inside the womb (stillbirth or fetal death); or a baby may die shortly after or within one month of birth.
2. The birthing person develops blood clots in their legs after giving birth. This is more likely to occur after a cesarean (abdominal) delivery than after a vaginal birth.
3. The doctor must remove the birthing person's uterus (womb) to stop heavy, uncontrollable bleeding. The birthing person cannot become pregnant again after this operation.
4. The birthing person has a problem after a blood transfusion such as an allergic reaction, fever, or infection. The chance of contracting hepatitis (from a transfusion) is 1 in 100,000; the chance of contracting HIV is less than 1 in 1,000,000.
5. The birthing person dies during childbirth (less than 1 in 10,000). Causes might include very heavy bleeding, high blood pressure, blood clots in the lungs, and other medical problems.
6. Birthing people who have a higher body weight ("body mass index") may be at risk for additional complications related to childbirth (infection, blood clots, cesarean delivery). Your obstetrician or midwife may recommend preventive medications or other therapy to reduce your risk of complications.

SUMMARY

Most babies are born healthy. Most birthing people go through labor and birth without serious problems. But pregnancy and childbirth do have some risks. Many of the possible problems are frightening, but most are uncommon. The most serious events are very rare.

Your health care team will do its best to identify any problems early and offer you treatment. Your team looks forward to caring for you and delivering a healthy baby.

APPENDIX D: ABOUT YOUR CARE DURING LABOR AND BIRTH

Authorization for Obstetrical Care

- I have read *About Your Care During Labor and Birth*.
- I understand what has been discussed with me, including this form. I have been given the chance to ask questions and have received satisfactory answers.
- No guarantees or promises have been made to me about expected results of this pregnancy.
- I am aware that other risks and complications may occur. I also understand that during the remainder of my pregnancy, or during labor, unforeseen conditions may be revealed that require additional procedures.
- I know that anesthesiologists, pediatricians, resident doctors, and other clinical students/staff may help my doctor or midwife.
- I retain the right to refuse any specific treatment.
- All of my questions have been answered.

I consent to obstetrical care during my birthing experience. I understand that some of the procedures described above may occur. I retain the right to refuse any specific treatment. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.

Patient Name (print)

DOB or Patient ID#

Patient Signature

Date

Time

Clinician Name (print)

Clinician Signature

Date

Time

- I accept blood transfusions in the case of a life-threatening medical emergency.
- I refuse blood transfusion under any circumstances and have signed a separate form specifically for the refusal of blood products.

Patient Signature

Date

Time

APPENDIX E

Breech Version or External Cephalic Version

If your baby is in the breech (buttocks down) position late in your pregnancy, the following explains a procedure your doctor or midwife may try to turn the baby to a head down position.

About 4 out of 100 babies are in the breech position after 37 weeks. This increases some risks for the baby. Breech babies have a slightly higher than average chance of birth injury. The birthing person has a high chance of cesarean delivery. For these reasons, you and your doctor or midwife may try to turn your baby.

This procedure is carried out in the hospital. An ultrasound is used to see the baby's position. This helps the doctor or midwife decide how to push on your belly. Your baby's heartbeat is checked during the procedure. A drug may be given to help your uterine muscles relax (it may make your heart beat faster). Then, the doctor or midwife will push on the baby through your abdominal wall in an attempt to turn it.

After the procedure, your baby's heartbeat is checked again. If you are Rh negative, then Rh immune globulin is usually given at this time.

About half the time, the baby can be turned into the head down position. Usually, once turned, the baby will stay head down.

Sometimes, the baby turns back to breech.

If successful, turning your baby head down reduces the chance of a cesarean. But it is associated with a number of risks.

- During the turning, your baby's heart rate may fall. This is not uncommon. The heart rate usually returns to normal quickly.
- The procedure may start your labor or cause your water to break. For this reason, the attempt to turn the baby is usually done within a few weeks of the due date. By then, the baby should be mature.
- In less than 1 out of 100 cases, the baby can be entangled in the umbilical cord during the turning.
- In less than 1 out of 200 of cases, the placenta may separate from the wall of the uterus. If this happens, the blood flow to the baby is reduced. That can be dangerous for the baby.
- If a problem does occur, an emergency cesarean delivery may be needed. Rarely, a problem will happen hours or days after the version.
- In very rare instances, the baby can die.

APPENDIX E: BREECH VERSION OR EXTERNAL CEPHALIC VERSION

Authorization for Breech Version or External Cephalic Version

- I have read *Breech Version or External Cephalic Version*.
- I understand what has been discussed with me, including this form. I have been given the chance to ask questions and have received satisfactory answers.
- No guarantees or promises have been made to me about expected results of this pregnancy.
- I know that anesthesiologists, pediatricians, resident doctors, and other clinical students/staff may help my doctor or midwife.
- I retain the right to refuse any specific treatment.
- All of my questions have been answered.

I consent to breech version (external cephalic version). Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.

_____ Patient Name (print)	_____ DOB or Patient ID#	
_____ Patient Signature	_____ Date	_____ Time
_____ Clinician Name (print)		
_____ Clinician Signature	_____ Date	_____ Time

APPENDIX F

Delivery Following a Previous Cesarean Delivery

If you have had one baby by cesarean delivery, you may have some questions about what happens in the next pregnancy. First, you must discuss the situation with your doctor or midwife. You will have to plan for another cesarean, or to try for a “trial of labor” and a vaginal delivery. If you want to try for a vaginal delivery, the following explains the risks and benefits.

IS A TRIAL OF LABOR RIGHT FOR YOU?

1. During your previous cesarean(s), a cut was made in your belly and uterus (womb). If the cut was in the lower part of your uterus—and sideways—then it is usually strong. The risk of the scar tearing during labor is low.
2. If you had a low, sideways cut, then you can safely attempt labor and a vaginal delivery. If you have had more than one cesarean, you can consider vaginal delivery, but the risk of rupture of the scar during labor goes up with each previous cesarean.
3. If your cesarean cut was in the lower part of your uterus—but up and down—then the risk of your scar tearing is higher than if it was sideways.
4. If your cesarean cut was in the upper part of your uterus and up and down (a classical cesarean delivery), then a vaginal birth is not recommended.
5. Your doctor or midwife will need to know the type of cut you had in your previous cesarean(s). If your records are not available, the two of you will have to talk and decide if a trial of labor is right for you without having the information about your previous cesarean(s).

WHAT ELSE IS NEEDED FOR A TRIAL OF LABOR?

1. Your pelvis should be judged adequate.
2. You should have no other uterine scars.
3. An obstetrician and other medical team members must be immediately available if you need an emergency cesarean.

HOW SUCCESSFUL IS A TRIAL OF LABOR?

1. From 60 to 80 percent of birthing people who try labor give birth vaginally. Even after two cesareans, the success rate is relatively high.
2. Birthing people with bigger babies have a lower success rate. So do birthing people whose previous cesarean was done because their labor slowed or stopped.

WHAT ARE THE BENEFITS AND RISKS OF A VAGINAL BIRTH?

1. The birthing person usually has a faster recovery time, shorter hospital stay, and less discomfort. You have less chance of blood transfusion and postpartum infection. You avoid the risks of surgery (cesarean). Vaginal birth also lowers your baby’s risk of breathing difficulty in the first few hours of life.
2. If your trial of labor is not successful, you will need an “unplanned” cesarean. An unplanned cesarean has more risk for you and your baby than a planned cesarean. This includes a higher chance of infection, blood transfusion, and a uterine tear.
3. After a previous cesarean, a uterine rupture (tear) can occur during a future pregnancy or labor. If you have a low, sideways cut, the risk is less than one percent. If your uterus does tear, you will need an emergency cesarean. Your baby may be injured or die from a uterine rupture. Occasionally, the uterus cannot be repaired and a hysterectomy (removal of the uterus) may be needed. Rarely, other organs such as the bladder or bowel may be injured from a uterine rupture or emergency cesarean.
4. The risk for rupture of the scar also goes up if your labor is induced, especially if your cervix is not ready for labor.
5. The safety of a vaginal birth (after cesarean) with twins, breech babies, or after more than one previous cesarean, is less well studied.

APPENDIX F: DELIVERY FOLLOWING A PREVIOUS CESAREAN DELIVERY

WHAT ARE THE BENEFITS AND RISKS OF A SCHEDULED REPEAT CESAREAN DELIVERY?

1. A repeat cesarean can be planned and the date chosen. You avoid any chance of a long labor. The risks of attempting vaginal delivery are avoided.
2. If a repeat cesarean is planned more than seven days prior to your due date, then your baby has more risk for problems.
3. The infection rate is higher in patients who deliver by cesarean than for those who have vaginal births.
4. Blood loss is usually more with a cesarean than with a vaginal delivery. Approximately 12 in 1,000 of all patients who have cesareans require blood transfusion.
5. Injury to the urinary system occurs in less than 1 in 200 cesarean births. These problems are usually identified and fixed at the time of birth.
6. Injury to the bowel (the intestines, colon, or rectum) is very rare, occurring in fewer than 1 in 1,000 cesareans. If an injury to the bowel occurs, it will usually be recognized and fixed at the time of birth.
7. Occasionally, the placenta in a future pregnancy can implant over the old scar. This increases the risk of bleeding and premature delivery in that pregnancy. The chance of the placenta implanting in the wrong place increases with each cesarean.
8. Having one baby delivered by cesarean increases the chance of a cesarean for your next pregnancy. Each cesarean increases the risk of scarring and may increase the difficulty of the next cesarean surgery. There is also an increased risk for rupture of the uterus in future pregnancies if labor is tried.
9. Rarely, infertility may result from internal scar tissue.
10. Rarely, a hysterectomy (removal of the uterus) can be required.

WHO SHOULD NOT TRY LABOR AND VAGINAL DELIVERY?

Trying labor and a vaginal delivery following a previous cesarean is not recommended when the risks are greater than the benefits.

1. You've had a previous cesarean delivery with an up and down cut in the upper part of your uterus (a classical cesarean delivery).
2. You've had some previous uterine surgery, including some myomectomies (fibroid removal).
3. You've had more than two consecutive (back to back) cesareans and no prior or interval vaginal deliveries.
4. You've had a prior uterine rupture or tear.
5. Your pelvis too small.
6. Medical or obstetrical problems prevent vaginal delivery.

APPENDIX F: DELIVERY FOLLOWING A PREVIOUS CESAREAN DELIVERY

Authorization for Delivery Following a Previous Cesarean Delivery

- I have read *Delivery Following a Previous Cesarean Delivery*.
- I understand what has been discussed with me, including this form. I have been given the chance to ask questions and have received satisfactory answers.
- No guarantees or promises have been made to me about expected results of this pregnancy.
- I know that anesthesiologists, pediatricians, resident doctors, and other clinical students/staff may help my doctor or midwife.
- I retain the right to refuse any specific treatment.
- All of my questions have been answered.

I have chosen to attempt a trial of labor and vaginal delivery. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.

_____		_____	
Patient Name (print)		DOB or Patient ID#	
_____		_____	_____
Patient Signature		Date	Time
_____		_____	
Clinician Name (print)			
_____		_____	_____
Clinician Signature		Date	Time

APPENDIX G

The Delivery of Twins

If you are having twins, the following explains possible events and risks related to your labor and delivery.

TIMING OF DELIVERY

- About 40 percent of twin pregnancies begin labor early.
- Sometimes, medical problems require an early delivery.
- Almost all patients with twins give birth before or by their due dates.

ROUTE OF DELIVERY

The recommended route of delivery depends in large part on how the babies are presenting.

- Both heads are down: vaginal delivery for both babies.
- The first baby is not head down: cesarean is most often recommended.
- The first baby is head down, the second baby is buttocks down or sideways, the options are:
 - cesarean delivery of both twins;
 - vaginal delivery of the first baby, attempt to turn the second baby for vaginal delivery;

- vaginal delivery of the first baby, breech vaginal delivery of the second baby; or
- vaginal delivery of the first baby, cesarean delivery of the second baby (uncommon).

Each option has risks.

- Vaginal delivery poses risks for the second baby, including birth trauma (rare).
- A cesarean includes the risk of bleeding, infection, and surgical injury to the bowel or bladder.

Vaginal breech delivery of the second twin is not recommended when:

- the second baby is estimated to be much larger than the first,
- the birthing person's pelvis is judged to be too small to allow the baby to deliver safely, or
- the baby is very small (less than 4 pounds) or very early (less than 32 weeks).

APPENDIX G: DELIVERY OF TWINS

Authorization for the Delivery of Twins

- I have read *The Delivery of Twins*.
- I understand what has been discussed with me, including this form. I have been given the chance to ask questions and have received satisfactory answers.
- No guarantees or promises have been made to me about expected results of this pregnancy.
- I know that anesthesiologists, pediatricians, resident doctors, and other clinical students/staff may help my doctor or midwife.
- I retain the right to refuse any specific treatment.
- All of my questions have been answered.

I understand that some of the procedures described above may occur. I retain the right to refuse any specific treatment. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.

Patient Name (print)

DOB or Patient ID#

Patient Signature

Date

Time

Clinician Name (print)

Clinician Signature

Date

Time

APPENDIX H

Primary Cesarean Delivery on Patient Request

THE BENEFITS AND RISKS OF A SCHEDULED ELECTIVE PRIMARY CESAREAN DELIVERY

1. A cesarean delivery can be planned; the date can be chosen.
2. You may not experience labor.
3. The most common problems with cesarean delivery are hemorrhage (uncontrolled bleeding) and infection. Both are higher risk for cesarean deliveries than for vaginal births.
4. For the birthing person, blood loss is usually greater with a cesarean than with a vaginal delivery. Approximately 12 in 1,000 of all patients having a cesarean need a blood transfusion.
5. Injury to the urinary system (the bladder and drainage to and from the bladder) occurs in less than 1 in 200 patients who deliver by cesarean. These problems are usually identified and repaired at the time of the cesarean. Vaginal delivery does not eliminate risk of injury to the urinary system.
6. Injury to the birthing person's bowel (intestines, colon, or rectum) is rare at the time of cesarean. It occurs in less than 1 in 1,000 cesareans. Such an injury will usually be recognized and fixed at the time of the cesarean. Injury to the birthing person's bowel almost never happens after a vaginal delivery.
7. A cesarean delivery can result in serious problems in subsequent pregnancies. Occasionally, the placenta in a future pregnancy implants over the old cesarean scar, which is usually near the cervix (the opening of the womb to the birth canal). This increases the risk of bleeding and premature delivery. The chance of the placenta implanting in the wrong place increases with each additional cesarean.
8. Having had one cesarean increases the chance of having another one. Each cesarean increases the risk of scarring afterwards and may increase the difficulty of future surgeries. There is also a small but increased risk for rupture of the uterus during labor for patients who have had a previous cesarean.
9. Rarely, the inability to get pregnant, or chronic pelvic pain, may result from scar tissue (adhesions) that may form after cesarean delivery.
10. Rarely, a hysterectomy (removal of the uterus) may be needed for the treatment of uncontrollable bleeding.

APPENDIX H: PRIMARY CESAREAN DELIVERY ON PATIENT REQUEST

Authorization for Primary Cesarean Delivery on Patient Request

- I have read *Primary Cesarean Delivery on Patient Request*.
- I understand that I have the option for vaginal delivery and that I do not have specific medical indications for cesarean delivery.
- I understand the risks and benefits of an elective primary cesarean delivery as explained above and as explained by my clinician. I am aware that other risks and complications may occur.
- I understand what has been discussed with me, including this form. I have been given the chance to ask questions and have received satisfactory answers.
- No guarantees or promises have been made to me about expected results of this pregnancy.
- I am aware that other risks and complications may occur. I also understand that during the remainder of my pregnancy, or during labor, unforeseen conditions may be revealed that require additional procedures.
- I know that anesthesiologists, pediatricians, resident doctors, and other clinical students/staff may help my doctor or midwife.
- I retain the right to refuse any specific treatment.
- All of my questions have been answered.

I request and consent to elective primary cesarean delivery. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.

Patient Name (print)

DOB or Patient ID#

Patient Signature

Date

Time

Clinician Name (print)

Clinician Signature

Date

Time