GROW-WI
GATHERING THE RURAL OB WORKFORCE IN WI

Project ECHO®

Gathering the **R**ural **O**B **W**orkforce in **WI**
GROW-WI ECHO Program

How to Join:
https://iecho.org/public/program/PRGM17425658124325CC96FHKX3

For attendance purposes, please text the code PEVREK to 608-260-7097.

Session Date: May 27, 2025
Facilitator: Allegra Ponshock, MD

	Topic	**Presenter**
Case Presentation	Hospital transfer of Amish grandmultip for medical induction	Katie Breitenmoser, CPM, LM Windy Hill Midwifery, LLC, Merrill, WI
Educational Presentation	Scope of Practice of Licensed Midwives in WI	Korina Bauer, RN, CPM, LM Co-President - WI Guild of Midwives, Iola, WI

Agenda:

7:30 – 7:35 AM – Welcome and Introductions
-Text-in your attendance, even if you do not plan to claim Continuing Education credits.

7:35 – 8:00 AM – Case Presentation

8:00 – 8:30 AM – Educational Presentation

Continuing Education Credits:
To claim CE credit, **you must complete the evaluation form after each session**.
ICEP will email you a link to the evaluation form after texting in for attendance.

Interprofessional
Continuing Education Partnership
UNIVERSITY OF WISCONSIN-MADISON

GROW-WI ECHO (Gathering the Rural OB Workforce in WI)
2025-2026
Scope of Practice of Licensed Midwives in WI
May 27, 2025
Korina Bauer, RN, CPM, LM; Katherine Breitenmoser, CPM, LM

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
MD/DO, RN, APRN, Physician Assistants, Certified Nurse Midwives, Students

Objectives:
1. Differentiate the scope of practice of the Certified Professional Midwife (CPM), Certified Nurse Midwife (CNM) and that of a Doula.
2. Define the general scope of Licensed Midwifery (LM) care in WI.
3. Explain and apply appropriate consultation, collaboration and transfer of care between LM and MD provider.

Policy on Disclosure
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** **Ineligible companies** are those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The ACCME does not consider providers of clinical service directly to patients to be ineligible companies.*

Name	Role	Financial Relationship Disclosures	Discussion of unlabeled/unapproved uses of drugs/devices in presentation	COI completion date
Korina Bauer, RN, CPM, LM	Presenter	No relevant financial relationships with ineligible companies to disclose.	No	4/11/2025
Katherine Breitenmoser, CPM, LM	Presenter	No relevant financial relationships with ineligible companies to disclose.	No	4/10/2025
Jillian Landeck, MD	RSS Chair	No relevant financial relationships with ineligible companies to disclose.	NA	3/25/2025
Jenny White	RSS Coordinator	No relevant financial relationships with ineligible companies to disclose.	NA	3/27/2025
Korina Bauer, RN, CPM, LM	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/25/2025
Bonnie Brown, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/8/2025
Jensena Carlson, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/27/2025
Lee Dresang, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/17/2025
Rachel Hartline, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/15/2025
Ryan Luellwitz, DO	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/26/2025
Rebecca Pfaff, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/6/2025
Allegra Ponshock, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/29/2025
Ryan Spencer, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/31/2025
Shannan Stephens, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/10/2025

Accreditation Statement

In support of improving patient care, the University of Wisconsin–Madison ICEP is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Credit Designation Statements

The University of Wisconsin-Madison ICEP designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1.0 ANCC contact hour(s).

The University of Wisconsin–Madison ICEP, as a member of the University Professional & Continuing Education Association (UPCEA), authorizes this program for 0.1 CEUs or 1.0 hour.

Welcome!

We will get started shortly.

Feel free to share your name, specialty/role, and practice location in the chat.

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American Nurses Credentialing Center (ANCC)

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1 ANCC contact hour.

Continuing Education Units

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- The planning committee has no conflicts of interest to disclose.

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Attendance

- For attendance, please text the code PEVREK to 608-260-7097
- Please text for attendance, **even if you are *not* claiming** continuing education credit.

Continuing Ed Credit

To receive continuing education credit:

1. Log your attendance (as above)
   - Create an ICEP account if you don't already have one.

2. Fill out the session evaluation form to receive credit – **REQUIRED for credit.**
   - A link to the evaluation will be sent after you text the code.

**Continuing Education Units with the Midwifery Education Accreditation Council are coming!

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Planning Team

Korina Bauer, RN, CPM, LM – WI Guild of Midwives, Iola, WI

Bonnie Brown, MD – UW DFMCH

Jensena Carlson, MD – UW DFMCH

Lee Dresang, MD – UW DFMCH

Rachel Hartline, MD* – Upland Hills Health, Dodgeville, WI

Jillian Landeck, MD* – UW DFMCH

Ryan Luellwitz, MD – UW OB GYN

Rebecca Pfaff, MD – Forks Community Hosp, Forks, WA

Allegra Ponshock, MD* – Mile Bluff Med Ctr, Mauston, WI

Ryan Spencer, MD – UW OB GYN

Shannan Stephens, MD – Gundersen OB GYN, La Crosse, WI

Jenny White* – UW DFMCH

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* Core Facilitation Team

Friendly Reminders

- Video appreciated
- Use chat function to ask questions or raise hand if able
- Mute microphone when not speaking
- Maintain confidentiality, no PHI
- Didactic will be recorded
- Mission is to empower those working in rural settings
- Our diversity of perspectives, specialties, practice scopes are our strength
- **"Coming together is a beginning. Keeping together is progress. Working together is success."** - Henry Ford

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Announcements

Please join us next month!

Tuesday, June 24th , 7:30-8:30 am

Psychopharmacology Principles for Perinatal Patients

Christina Wichman, DO

Professor of Psychiatry & Obstetrics and Gynecology
Medical Director, The Periscope Project

THE PERISCOPE PROJECT
PERINATAL SPECIALTY CONSULT PSYCHIATRY EXTENSION

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Interested in sharing a case?

Email jennifer.white@fammed.wisc.edu

- Slide template shared, 10 min for details of case
- Priority to cases from rural and resource-limited settings
- No PHI
- Include on CV as a state presentation

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Rural OB Case Presentation

Katherine M. Breitenmoser CPM, LM

Windy Hill Midwifery, LLC

May 27th, 2025

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Disclosures & Disclaimers

- No Disclosures

- PATIENT RELATIONSHIP DISCLAIMER
  - PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a Project ECHO® setting.

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Case Introduction

- Hospital transfer of Amish grandmultip for medical induction due to:
  - Measuring SGA
  - Decreasing AFI
  - Postterm pregnancy

- Discussion Questions:
  - What can effective collaboration between LMs and Hospital-based providers look like?
  - What cultural considerations are important/appreciated when working with Plain families?

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Cultural overview of Plain Families

- Plain families in WI: Amish, Mennonite, German Baptist
- Healthcare decisions heavily influenced by:
  - Religious & familial preferences
  - Cost of care
  - Tendency/preference for large families
- Often living below poverty level
- Eighth grade education
- Obstetric care often complicated by:
  - Nutritional deficiencies, dietary challenges
  - High parities (mainly PPH & fetal malposition)
  - Logistics – limited phone access, driver availability, lack of electricity, etc.
  - Tendencies to decline routine prenatal testing, ex. dating & anatomy scans, routine bloodwork, etc.
  - Genetic disorders
- Amish DO NOT fly, other Plain families prefer not to

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Social History

- Very conservative Amish family
  - No electricity
  - Phone – ¼ mile away, no voicemail
  - Horse/buggy transportation, difficult to find available drivers
- Nutrition is a CHALLENGE
  - Dietary restrictions
  - Seasonal food availability/refrigeration
  - Income limitations
  - Conflicting nutritional advice from another community member
- Parents had declined genetic screening

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Medical History:

- Cholecystectomy (5 years prior)
- Hx of recurrent pancreatitis
- Hx of superficial thrombophlebitis
- 2 of MOB's siblings: Classical Achondroplasia (possibly Ellis-Van Creveld syndrome)

Obstetric History:

- G11P8, 38 yo, B+
- (very!) Precipitous birth (x3)
- PPH (x2)
- Measuring SGA (x3)
  (but yielded 7 to 8.5# babies)
- Postterm to 41 wks (x3) and 42 (x1)

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Prenatal Overview

- 7.0 weeks – Call to establish care
  - Declined appt, “until the scholars are back in school for the year.”
  - 1st tri. Dating scan: Discussed & declined
  - EDD est’d via LMP dating
- 16.0 – Home visit + labs
  - Declined updating OB Panel
  - All other labs WNL: CBC, MPC, AbSc, Iron/Ferritin, Vit. D, Thyroid
- 20.5 – Home visit
  - Anatomy Scan: Discussed & declined
  - All else WNL

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Prenatal Overview

- 26.5 – Home visit
  - GDM screening: passed
  - Discussion re: Hx of PPH and management/safety strategies
    - Family prefers active 3rd stage management
- 32.0 & 37.0 – Home visits
  - GBS screening: Discussed & declined
  - Hgb recheck – WNL
  - Measuring 1 cm small for dates
- 39.0 – Home visit
  - Measuring 3 cms small
  - Discussion of fetal surveillance – methods, benefits, interventions, etc.
  - Family declines in light of enthusiastic fetal movement

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Prenatal Overview

- 39.5 – Phone call
  - Client reports decrease in fetal movement
- 40.0 – Office visit
  - BPP + fetal measurements – 8/8, measuring at 38 wks, HC/AC WNL
  - Physician phone consult for measuring SGA
- 41.0 – Home visit
  - Early labor activity
  - VE requested: 0 cms, cx firm/posterior, 25% eff., baby vertex but ballotable
  - Fetal movements noted, “but not much compared to the other children”

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Prenatal Overview

- 41.2 – Office visit
  - Fetal growth assessment, repeat BPP (7/8 for AFI)
- 41.4 – Physician Consult
  - NST (reactive), BPP (7/8)
  - Discussed IOL options/risks/benefits
  - Family elected to wait. Physician accommodated, requested frequent cont'd monitoring & recc'd IOL if AFI drops further or HC/AC becomes abnormal
- 42.0 – Office visit
  - BPP (6/8), fetal growth assessment (Slightly abnormal HC/AC)
  - Decision to transport for IOL

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Highlights of Dx/management plan:

- Decision to send family home w/ plans to repeat BPP + fetal growth
- Induce if:
  - AFI drops
  - NST is less than reactive
  - Growth becomes asymmetric
- Communicative team approach
- Physician gives room for family to confer w/ midwife, not high-pressure!
- TOC for IOL at 42.0

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Timeline/L&D details:

2000 – We present to hospital for induction, CNM receiving

- Induction options discussed incl'ng IV fluids, oxytocin, misoprostol (AROM not offered due to low AFI)
- Begin (2) lg bore IVs due to Hx of PPH
- Start w/ simple fluid bolus = effective

0030 – Onset of noticeably stronger UCs, q 3-4 min.s.

- Family declines VE (but we elect to use 0030 as the beginning of active labor)

0150 – Beginning of some late decels (mild, but there). Patient requests VE & we discuss speeding things up…politely.

- 8/100/+1
- Begin oxytocin at 0.5 (which I didn't even know was possible)

Timeline/L&D details (cont'd):

0222 – Onset 2nd stage

0224 - SROM, mec-stained fluid

0224 – NSVD (LOA, no nuchal cord)

- Vigorous baby boy, 2722g (6#0)
- APGARs of 8/9 (color)
- Gentle stimulation; no suction or other resus. Measures
- SGA by visual assessment

0230 – Increase oxytocin, initiate TXA, 600 mcg miso PR

- Brisk initial bleeding (+ Hx of PPH) inspired fast response
- QBL – 353

0238 – Placenta (w/ incomplete trailing membranes)

- Mec stained, partially circumvallate, velamentous cord insertion, 2VC

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Postpartum/Neonatal update:

- Pediatrician mostly concerned with undescended R testicle….unfazed by lack of neonatal void (after SGA, 2VC, and AFI of nearly 0)
- Family DC'd at 14 hrs PP w/ their friendly Amish Taxi Service.
- 24-hr check: still no void. Family supplementing nursing w/ syringe feeds of EBM to ensure intake. Passed CCHD screening (and metabolic screening)
  - Call to local NICU, neonatologist unconcerned.
  - Void @ 30 hrs of age…finally!
- Cont'd observation & weight checks until 6 weeks of age
- 5 months later: cont'd reports borderline FTT, diaphoresis, occ./positional heart arrhythmia, and persistent colic
- Multiple clinic trips and testing: Dx of Crohn's!
- Switch to Crohn's-friendly diet = much happier & healthier baby!

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Key learning points:

- Families who desire an out-of-hospital birth will embrace an appropriate medical transfer when done in a thoughtful, informed, and culturally sensitive way
  - Continuity of care is key!
  - Give families time & space to make a decision
    - Be willing to step out of the room
    - Don’t be offended by Pennsylvania Dutch conversation
- Give truly Informed Consent
  - Families can perceive manipulation

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System Considerations/Areas for Improvement:

- DISTANCE (to higher level OB care):
  - We travel 1.5 hrs for care that's collaborative and culturally-sensitive.
- Cost of care:
  - The medical system wants to do EVERYTHING (everywhere, all at once)…that adds up quickly and is intimidating, esp. for cash-pay families.
    - Consequence: Families reflexively reject options they would otherwise consider
- Understand your local midwives
  - Not all LM practices look, smell, feel the same
  - Take the time to understand scope of care, standing orders, etc.
  - Be willing to consult/collaborate

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Open Discussion

Questions? Observations?

Katie Breitenmoser CPM, LM

katie@windyhillmidwifery.com

(715) 581-0888

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Scope of Practice of Licensed Midwives in WI

Korina Bauer RN CPM LM
In the Beginning Midwives
Korinaitb@protonmail.com 715-853-2082
5/27/25

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Disclosures

- Wisconsin Guild of Midwives- President Co-Chair
- Wisconsin Midwifery Advisory Committee- Chair

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Objectives

1. Differentiate the scope of practice of the Certified Professional Midwife (CPM), Certified Nurse Midwife (CNM) and that of a Doula.
2. Define the general scope of Licensed Midwifery (LM) care in WI.
3. Explain and apply appropriate consultation, collaboration and transfer of care between LM and next level medical provider.

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Midwifery Model of Care

Monitoring the physical, psychological, and social well-being of the client throughout the childbearing cycle

Providing the client with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support

Minimizing technological interventions

Identifying and referring clients who require obstetrical attention

The application of this person/client-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

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North American Registry of Midwives

The Certified Professional Midwife credential, issued by NARM, is accredited by the National Commission for Certifying Agencies (NCCA), the accrediting body of the Institute for Credentialing Excellence (ICE, formerly NOCA).

The mission of ICE is to promote excellence in credentialing for practitioners in all occupations and professions.

The NCCA accredits many healthcare credentials, including the Certified Nurse-Midwife. NCCA encourages their accredited certification programs to have an education evaluation process so candidates who have been educated outside of established pathways may have their qualifications evaluated for credentialing.

The CPM is the only NCCA-accredited midwifery credential that includes a requirement for out-of-hospital experience.

https://narm.org/about/the-cpm-credential/history-of-the-development-of-the-cpm-credential/

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National Association of Certified Professional Midwives (NACPM)

A Certified Professional Midwife (CPM) is a knowledgeable, skilled and professional primary maternity care provider. CPMs are trained and credentialed to offer expert care, education, counseling and support to birthing people during the pregnancy, birth and the postpartum periods. CPMs practice as autonomous health professionals working within a network of relationships with other care providers who can provide consultation and collaboration when needed. All CPMs meet the standards for certification set by the North American Registry of Midwives (NARM).

https://www.nacpm.org/whoarecpms

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Certified Nurse Midwife (CNM)(CM)

The American College of Nurse-Midwives affirms that certified nurse-midwives (CNMs) and certified midwives (CMs) practice in accordance with the following standards. Midwifery as practiced by CNMs and CMs: encompasses the independent provision of care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care. Midwives also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life. Midwives provide care for all individuals who seek midwifery care, inclusive of all gender identities and sexual orientations. CM/CNMs exist in a community of all midwives, and we respect and elevate the importance of having midwifery care available for all people who want it.

https://midwife.org/about-midwifery/

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Certified Professional Midwife

- Work in the community setting, have offices, provide home birth and or birth center birth services
- Consult with collaborative providers as needed
- Licensed by the state
- CPM's do not have to be a nurse first.

Certified Nurse Midwife

- Primarily work in hospital settings
- Work within hospital protocols and have a physician that oversees their practice
- Regulated by the state board of nursing
- All CNM's have received a nursing degree first

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Doula

- A Doula is a trained professional who provides continuous **physical, emotional and informational support** to their client before, during and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible.

  - A doula does not provide medical assessment, evaluation or procedures

https://www.dona.org/

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Licensed Midwife (LM)

- As of June 15, 2024, CPMs have a path to licensure in 36 states and the District of Columbia
- Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming.
- **Wisconsin CPMs have been licensed since 2006**

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Rules and Regulations for LM's in WI

In 2006, the Wisconsin Department of Safety and Professional Services (formerly the Department of Regulation and Licensing) created licensure for maternity care providers specializing in out of hospital care. At that time, the State created Rules and Standards of Practice for Licensed Midwives.

https://wisconsinguildofmidwives.org/rules-regulations-for-licensed-midwives-in-wisconsin/

https://docs.legis.wisconsin.gov/statutes/statutes/440.pdf#page=42

https://dsps.wi.gov/Pages/Professions/MidwivesLicensed/Default.aspx

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Scope of Practice- Informed Consent

SPS 182.02 Informed consent.

(1) Disclosure of information to client. A licensed midwife shall, at an initial consultation with a client, provide a copy of the rules promulgated by the department under subch. XIII of ch. 440, Stats., and disclose to the client orally and in writing on a form provided by the department all of the following:

(a) The licensed midwife's experience and training.

(b) Whether the licensed midwife has malpractice liability insurance coverage and the policy limits of the coverage.

(c) A protocol for medical emergencies, including transportation to a hospital, particular to each client.

(d) A protocol for and disclosure of risks associated with vaginal birth after a cesarean section.

(e) The number of babies delivered and the number of clients transferred to a hospital since the time the licensed midwife commenced practice of midwifery.

(f) A statement that the licensed midwife does not have the equipment, drugs or personnel available to perform neonatal resuscitations that would normally be available in a hospital setting.

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Scope of Practice – Testing Care and Screening

- Monthly prenatal appointments until 28 weeks, appointments every other week from 28-36 weeks, then weekly until birth
- Additional visits as needed
- Routine prenatal labs and follow up labs as needed
- Routine ultrasound services
- Routine genetic screening services
- Additional monitoring and assessments as needed (i.e. growth ultrasounds, BPPs, etc)
- Schedule hour long appointments to provide relationship building and education

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Scope of Practice- Labor and Birth

- On-call support provided from 37-42 weeks.
- Continuous attendance in active labor
- Regular fetal heart tones assessment per ACNM guidelines for intermittent monitoring
- Regular vital signs assessment
- Assessment of labor and immediate postpartum course with careful attention to any deviations from normal
- Support of laboring parent and family
- Care for the birth of the placenta
- Assessment of bleeding in the immediate postpartum period (no less than 2 hours after the birth of the placenta)
- Assessment for any tearing and laceration repair as needed
- Immediate lactation support

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Scope of Practice- Postpartum Care

- Routine postpartum care at approx. 24 hr, 3 day, 1-2 weeks and 6 weeks. Usually these are 45-90 minutes long.
- Vitals assessments
- Assessments for bleeding and normal healing
- Monitoring laceration healing
- Mental health assessments and supports
- Any needed labs
- Lactation care, including mastitis care
- Filing of birth certificate

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Scope of Practice- Newborn Care

- Comprehensive newborn exam including neurological assessment after birth
- Administering Vitamin K and erythromycin as families so choose
- Routine newborn care at approx. 24 hr, 3 day, 1-2 weeks and 6 weeks. Usually these are 45-90 minutes long.
- Vitals assessments
- Regular weight monitoring
- Assessments of normal newborn behavior
- Lactation care
- Bilirubin monitoring
- Routine Newborn Screening - Newborn Metabolic Screening, Critical Congenital Heart Defect Screening, Hearing Screening

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Provider to Provider Consultations

- Indications provided for consultation in state statutes
- Midwives may choose to do so at any time for additional indications and needs
- Consultation does not preclude OOH birth
- Consulting providers may include OOH CNMs, hospital-based CNMs, OBs, PCPs, MFM physicians, Pediatricians, Neonatologists, or other specialists such as Hematologists or Endocrinologists

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Community to Hospital Transitions

- WI state statute gives a full list of required transfers of care
- Looks different in different communities and hospitals across the state
- Most often non-emergent and happens by car
- Midwives may use a transfer form for continuity of care
- Midwives accompany clients into the hospital and provide care records and a complete report to the hospital team
- Many midwives remain with families in the hospital through birth
- Continuity of care and collaboration are key for outcomes and positive experiences for all

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Examples of collaborative relationships

Sinai Bridge Program

Madison Hospital Direct Admissions Transfer Protocol

EMS trainings

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Sinai Bridge Program

- Aurora Sinai Medical Center- Women's Health
- CPM's and CNM's work together to facilitate points of care during pregnancy
- Families planning community birth can establish with a CNM for one appointment
- Facilitates obtaining lab, routine screenings, ultrasounds
- Pregnant person chart is on file with hospital system
- Midwife to midwife care planning as needed
- Ease of transfer as needed during labor, pp or for newborn
- Ease of discharge planning if transfer in then back to CPM for routine pp and newborn care

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Madison – Meriter Hospital

- Based on long-time and continued relationships with hospital care teams at both birthing hospitals
- Licensed Midwives call and speak directly with the hospital midwife on call who then initiates a direct admission onto her unit and into her care team
- Upon arrival, families go straight to Birth Suites and into a room - no triage is necessary
- Unless OB care is medically indicated, care remains with the hospital midwifery team
- No prior appointments with any other provider or the hospital care team is required during pregnancy
- Same process for ED and Children's Hospital transfers
- Discharge home often includes a warm hand off or records sharing to resume home care with an LM.

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EMS

- Many midwives around the state engage in regular trainings or collaborations with EMS teams
- Streamlining more emergent transfers or specialized transports with a provider on scene
- UW Primary Paramedic Training Program

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Resources

Transfer form

Informed Consent form

Please contact me at Korinaitb@protonmail.com for forms or follow up questions

Thank you!

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References

- https://wisconsinguildofmidwives.org/
- https://www.nacpm.org/
- https://narm.org/
- https://wisconsinguildofmidwives.org/rules-regulations-for-licensed-midwives-in-Wisconsin/
- https://www.nacpm.org/midwives-model-of-care
- https://midwife.org/about-midwifery/
- https://www.dona.org/what-is-a-doula-2/
- http://dsps.wi.gov.

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Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone number: (608) 266-2112

LicensE Portal: https://license.wi.gov/
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

LICENSED MIDWIVES – INFORMED CONSENT FORM

Last Name	First Name	MI	Former / Maiden Name(s)
Address (number street, city, state, zip code)			**Daytime Telephone Number**
			___ - ___ - ____

TRAINING: List location, type of training (self-study, apprenticeship, direct-entry school, nurse midwifery school) and dates of attendance.

Facility Name, City, State	Type of Training	Dates From (month/year)	Dates To (month/year)
		__ / ____	__ / ____
		__ / ____	__ / ____
		__ / ____	__ / ____
		__ / ____	__ / ____
		__ / ____	__ / ____
		__ / ____	__ / ____
		__ / ____	__ / ____

CERTIFICATION: List name and address of certifying body, date of certification and type of certification.

Name and City/State of Certifying Body	Type of Certification	Date of Certification
		__ / __ / ____
		__ / __ / ____
		__ / __ / ____
		__ / __ / ____
		__ / __ / ____

MIDWIFE EXPERIENCE:

1.	Total number of births attended:	
2.	Number of home births as primary/managing midwife:	
3.	Number of home births as primary assistant to the midwife:	
3.	Number of years in practice as primary midwife:	
4.	Number of births as doula/hospital support:	
5.	Number of clients transferred to a hospital since commencement of practice of midwifery:	

MALPRACTICE LIABILITY INSURANCE:

Do you have malpractice liability insurance coverage? ☐ Yes ☐ No List policy limits of coverage (if applicable):

Wisconsin Department of Safety and Professional Services

MEDICAL EMERGENCIES:
The following is my protocol for handling medical emergencies, including transportation to a hospital. Attach additional sheets if necessary.

VAGINAL BIRTH AFTER CESAREAN SECTION (VAC):
The following is my protocol for disclosure of risks associated with vaginal birth after a cesarean section. Attach additional sheets if necessary.

DISCLOSURE RELATING TO NEONATAL RESUSCITATIONS:
Licensed midwives do not have the equipment, drugs or personnel available to perform neonatal resuscitations that would normally be available in a hospital setting.

COPY OF DEPARTMENT RULES PROVIDED TO CLIENT: As required under Wis. Admin. Code § SPS 182.02(1), I certify that on this date I provided a copy of the Department's rules pertaining to the practice of midwifery to the client. **(List client name below.)**

Printed Name of Midwife	**WI License Number**
Signature of Midwife (If unable to provide a digital signature print and sign form.)	**Date**
	☐☐ / ☐☐ / ☐☐☐☐

ACKNOWLEDGEMENT BY CLIENT: I acknowledge that I have received the oral and written disclosures required under Wis. Admin. Code § SPS 182.02.

Printed Name of Client	
Signature of Client (If unable to provide a digital signature print and sign form.)	**Date**
	☐☐ / ☐☐ / ☐☐☐☐

Please bring copies of the following information with the patient:	**Important Phone Numbers**
□ Patient's chart – pertinent to this pregnancy or current medical conditions: (lab work, progress notes, prenatal, ultrasound reports) □ Labor notes and flowsheet □ Consent for Release of Medical Information to receiving hospital	**Hospital** **Doctor/CNM** **Pediatrician** **Other**

Transferring Practice _____ Phone # _____

Transferring Midwife _____

Date of transfer _____ via: _____Car _____Ambulance Time of transfer_____

Patient Name *(print)* _____ Age _____ DOB: _____

Name of Significant Other/Relationship _____

Type of transfer**:** ☐ Antepartum ☐ Intrapartum ☐ Postpartum

Indication for transfer _____

Interpreter required ☐ No ☐ Yes – What language? _____

PRENATAL INFORMATION

G____T_____P_____A_____ L_____ **EDD** _____ **Gestational Age** _____

Allergies ☐ NKDA ☐ Yes _____

Rh status ☐Pos ☐Neg **Hepatitis status** ☐Pos ☐Neg **GBS status** ☐Pos ☐Neg

Prenatal care received starting at _____weeks # of prenatal visits _____

Other Obstetrical or Medical Risk Factors

☐ No ☐ Yes _____

Labor Information

Status of membranes ☐ Intact ☐ Ruptured _____/_____date/time

Color ☐clear ☐mec ☐bloody ☐other _____

Contractions present ☐ No ☐ Yes Onset _____ Frequency_____

Duration _____ Intensity _____

FHR _____ **FHTs prior to transfer** ☐ Reassuring ☐ Non-reassuring

Cervical dilation ____cm _____% effacement _____station @ _____(time)

Delivery Information

Delivered _____/_____date/time EBL_____ Prior H/H_____

Other_____

Treatments/Vitals

IV present ☐ No ☐ Yes _____solution/rate (* change site *within* 8°)

Catheter gauge: _____ _____solution/rate

Last Void:_____ **Last PO Intake:** _____ type/time

Vital Signs at time of transfer BP___ P_____ R ____ T ____

Medications Received Prior to Transport

☐ None ☐ Antibiotics_____date/dose(s)

☐ Other _____

PATIENT INFORMATION FROM RECEIVING HOSPITAL UPON ADMISSION

Condition on admission ☐ Stable ☐ Critical ☐ Other _____

Date/Time patient arrived _____/____/_____@ _____

Name of Receiving RN _____ Accepting Physician _____

MATERNAL TRANSFER INFORMATION

Please bring copies of the following information with the patient:	**Important Phone Numbers**
□ Patient's chart – pertinent to this pregnancy or current medical conditions: (lab work, progress notes, prenatal, ultrasound reports) □ Labor notes and flowsheet □ Consent for Release of Medical Information to receiving hospital	**Hospital**_____ **Doctor/CNM**_____ **Pediatrician**_____ **Neonatal Intensive Care**_____

Transferring Practice _____ Phone # _____

Transferring Midwife _____

Date of transfer _____ via: _____Car _____Ambulance Time of transfer_____

Infant Name *(print)* _____

Name of Mother _____Name of Father_____

Indication for transfer _____

Interpreter required ☐ No ☐ Yes – What language? _____

PRENATAL INFORMATION FOR MOTHER OF INFANT

G____T_____P_____A_____ L_____ **EDD** _____ **Gestational Age** _____

Allergies ☐ NKDA ☐ Yes _____

Rh status ☐Pos ☐Neg **Hepatitis status** ☐Pos ☐Neg **GBS status** ☐Pos ☐Neg

Prenatal care received starting at _____weeks # of prenatal visits _____

Ultrasound ☐ None ☐ No concerns Other_____

Family Hx of Genetic Disorders ☐ None known Other_____

Other Obstetrical or Medical Risk Factors
☐ No ☐ Yes _____

Labor and Delivery Information

Rupture of Membranes _____/_____date/time ☐clear ☐mec ☐bloody ☐other _____

Delivered _____/_____date/time EBL_____ Prior H/H_____

Length of Labor 1st Stage_____ 2nd Stage_____3rd Stage_____

Complications of Labor and Delivery_____

Condition of Infant at Delivery: Apgars 1 minute_____5 minute_____10 minute_____

Resuscitation ☐ None ☐ Ongoing PPV for_____minutes Chest Compressions for _____minutes

Congenital Anomalies ☐ None Seen Description_____

Treatments/Vitals

Vital Signs at time of transfer T _____HR____ R ____ Quality of respirations_____

Condition of Infant Color_____ Tone_____Activity_____

Other Void_____ Stool_____ Feedings_____

Oxygen Received Prior to Transport ☐ None @___L by_____ at _____/_____Date/Time

Other Treatments_____

PATIENT INFORMATION FROM RECEIVING HOSPITAL UPON ADMISSION

Condition on admission ☐ Stable ☐ Critical ☐ Other _____

Date/Time patient arrived _____/____/_____@ _____

Name of Receiving RN _____ Accepting Physician _____

NEONATAL TRANSFER INFORMATION