ID#_____

Deb Phillips' Birth Supply List

- ❑ **Fem-dophilus probiotic by Jarrow Take all through pregnancy, twice/day at 34 week) Use as paste one week out. Treat partner same.
- ❑ Magnesium Glycinate for cramps and poops
- ❑ Newborn Kit from Local Health Unit (antibiotics for eyes and vit k) OR natural vit k from InHisHands.com
- ❑ Hemorrhoid cream Americaine 20% Benzocaine from pharmacy over counter for suturing and hemorrhoids
- ❑ In His Hand Deb Phillips Birth Kit ordered by 36 weeks Or get the following at Wal-Mart:
  - o 2 Bags of underpads (flat pads for bed; chux pads, NOT puppy pads,) about 30 thick ones
  - o 1 Bag of overnighter maxi pads, no bleach
  - o Adult pull-ups 4-5
  - o 1 Box of 4x4 gauze pads, check size, Band-Aid cushion-care
  - o Olive Oil, 8 oz., new
  - o Peroxide, new
  - o Alcohol, new
  - o Thermometer
  - o Nitrazine paper from Deb or In His Hands
  - o Viva brand paper towels or other soft brand
  - o 3 Ziploc bags, quart size
  - o Bulb Syringe, 3 oz., *no hard plastic end* Innovo clear twister bulb
  - o 2 Peri-bottles 8 oz. (ketchup, hair dye, or travel bottles, not Frida)
  - o Baby cap
  - o 2 Trash bags, large
  - o 2 flannel backed tablecloths, one for bed/one for floor
  - o Straws for mother
  - o Lansinoh cream and Haaka pump for breastfeeding
  - o Chlorophyll liquid (for strength after birth and bleeding) .
  - o Crampbark – get from Deb prenatally (only for repeat births)

- ❑ Flashlight with new batteries
- ❑ Diapers for baby
- ❑ 6 Receiving blankets and 4 washcloths
- ❑ 2 Sets of sheets*
- ❑ Large mixing bowl for set-up and big pot for herbs
- ❑ Snacks/juice for mom. If long birth something for midwives. Veggie or fruit tray
- ❑ Heating pad or hot water bottle
- ❑ Clothes for mom and baby
- ❑ Home-cooked meals stored in freezer (no dairy, no chocolate)
- ❑ Person to help with kids during birth, plan for postpartum support. No birth party.
- ❑ Post emergency phone numbers on fridge
- ❑ Midwife paid in full by 36 weeks
- ❑ Reading materials returned to Deb
- ❑ NORA tea – get from Deb
- ❑ Herbal bath supplies
  Get Herbs from Deb's house. She does not carry them in her car
  If RH- buy an Eldon Card from InHisHands.com
- ❑ Water Birth supplies:
  -Beach towel or robe
  -Extra towels
  -Little fish net, aquarium size
  -Take tub AND liner from Deb's house at 37 weeks
  -New, lead-free hose
  -Adapter for sink if needed
  -Return to Deb at 24 hour visit
- ❑ Bag packed in case of transport for baby and mom

Collect all items in a box by 36 wks, including clothes for mom/baby.

*Put protective liner on *made* bed in labor.. Cover with old set of sheets for birth.

Nice to have extras: natural vit k, footprinter, front-closure Bra, affirmations, silverettes, Lavender or Clary Sage essential oils
For extras: www.InHisHands.com

We use all of these products. Don't pick and chose!

ID#_____

Deb Phillips, CPM, LLM
Phone List

Deb……..501-833-3322 fax…..….501-350-1520 cell

Tajza Josephson…….....…..……503-856-6139

UAMS…….501-686-5964
Children's Hospital……..……..501-320-1100
Closest Hospital……...

Please do not come to your appointment if anyone in your household is sick. I cannot get viruses and pass them to the other mothers and/or miss births. My other clients would appreciate me not being exposed.
Be sure there is no one at your birth who has been directly exposed to a virus. Let no one in your home that has been exposed or has any sickness. No snotty nosed kids.
Protect your baby.

ID#_____

Deb Phillips, CPM, LLM **Return to Deb**

Intake

Date: _____ LMP:_____EDD:_____

Full Legal Name:_____Maiden:_____Date of Birth:_____ _

Address:_____City:_____Zip:_____County: _____ City Limits: Y / N

Phone Number: _____Married: Y / N

State of Birth: _____ Age:_____Race:_____Religious Preference:_____

SS#_____Occupation:_____Lvl of Ed:_____Insurance:_____

Father of Baby Full Name: _____WIC: Y / N

Phone Number: _____

Date of Birth: _____ State of Birth: _____ Age:_____Race:_____ Religious Preference:_____

SS# _____Occupation:_____Lvl of Ed:_____

Located by: _____ E-mail: _____

Previous pregnancy outcomes including miscarriages:									
Name	Birthdate	Birthweight	Hr/Labor	Vag/Surg	Wks Prg	Location	Mw/OB	Complications	Brstfd?

Gynecologic History:

G ___ P___ A___ M___ P___ L___ G: total pregnancies P: births A: abortions M: miscarriages P: preterm L: living children (not this baby)

Menstrual History: Menarche(age started): ___Cycle: ___ Flow: ____Regular: Y / N All contraception used:_____

PMS: Y / N Migraines: Y / N Difficulty conceiving: Y / N Nipples inverted/flat: Y / N Last Pap Date:____Results____

Pelvis/Genitals: Do you have: Warts/Varicose Veins/Scars/Cysts/Perineal problems/Prolapse/Incontinence/Abnormal pap

Health History

Circle those conditions that you have experienced:

History Since Last Menstrual Cycle: AbdominalPain/Bleeding/Spotting/Nausea/Vomiting/Discharge/Varicose veins/Hemorrhoid/UTI/Fever/Illness/ Ultrasound

Personal Health History: Pre-Preg Weight: _____ Height: _____ Blood Type: _____

Drug Allergies/ Allergies/Alcohol/Asthma/Drugs/Smoking/Anemia/UTI/Intestines/Hep//VD/Herpes/Infections/Injuries/Surgery/Ulcers/Thyroid/MRSA
Neurological/Blood/Psychiatric/TB/Lungs/BirthDefects/GeneticDisorders/Hypertension/Heart/Cancer/Diabetes/Epilepsy/Twins/Eating Disorder/Chronic Illness
Severe headaches, Eye/vision, Ear/hearing, Dental, Thyroid, Rheumatic fever, Blood clotting, Anemia, Hemorrhage, Hemorrhoids, TB, Skin disorders, Stomach , Ulcers, Chicken Pox, Bowels/colitis, Blood in stool, Gall bladder, Liver, Hepatitis, Hypoglycemia, Bladder or Kidney infection, Urinary surgery, Urethral dilation, Aching joints, Pelvic.back injuries, Seizures, Cancer, Hospitalizations, Surgeries.

Explain:_____

Maternal and Paternal Family Health History:

Drug Allergies/ Allergies/Alcohol/Asthma/Drugs/Smoking/Anemia/UTI/Intestines/Hep//VD/Herpes/Infections/Injuries/Surgery/Ulcers/Thyroid/MRSA
Blood /Neurological /Psychiatric/TB/Lungs/BirthDefects/GeneticDisorders/Hypertension/Heart/Cancer/Diabetes/Epilepsy/Twins/Eating Disorder/Chronic Illness

Explain:_____

Nutritional History: List food categories you regularly eat:_____avoid: _____

Physical: Any problems with your: Body/Eyes/Teeth/Mouth/Tongue/Skin/Back/Organs/Hands/Breasts/Legs/Feet _____

Socio-Economic (money, job, housing, family related) Changes: _____

Why Midwife Care: _____

Special Desires for Birth: _____

ID#_____

Name:_____ **Birthdate:** _____ **EDD:** _____

Have you ever had any of these:

- ❑ Yeast
- ❑ Trichomonas
- ❑ Group B Strep
- ❑ Bacterial vaginosis
- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ Syphilis
- ❑ PID/pelvic infection
- ❑ Genital sores
- ❑ Herpes __oral __ genital
- ❑ Condyloma (warts)
- ❑ Cervicitis
- ❑ Cervical surgery
- ❑ Cervical polyp
- ❑ Ovarian cyst
- ❑ Fibroids
- ❑ Endometriosis
- ❑ Abnormal bleeding
- ❑ Uterine surgery
- ❑ Breast lumps
- ❑ Breast surgery
- ❑ Infertility
- ❑ Other

Details:_____

During this pregnancy, have you had any of the following:

- ❑ Nausea
- ❑ Vomiting
- ❑ Fever
- ❑ Infections
- ❑ Dizziness
- ❑ Indigestion
- ❑ Leg cramps
- ❑ Rash
- ❑ Backache
- ❑ Swelling
- ❑ Constipation
- ❑ Diarrhea
- ❑ Urinary complaints
- ❑ Abdominal/pelvic pain
- ❑ Vaginal bleeding/spotting
- ❑ Bleeding gums
- ❑ Varicose veins
- ❑ Hemorrhoids
- ❑ Depression
- ❑ Loneliness
- ❑ Family/relationship problems
- ❑ Work problems
- ❑ Drug use legal/illegal
- ❑ Other

Details: _____

Have you used, experienced, or been exposed to any of the following during this pregnancy:

- ❑ Tobacco
- ❑ Alcohol
- ❑ Caffeine
- ❑ Marijuana
- ❑ Cocaine
- ❑ Street drugs
- ❑ Prescription Drugs
- ❑ Non-pres./OTC Drugs
- ❑ Vitamins
- ❑ Herbs
- ❑ Fumes/sprays
- ❑ X-rays
- ❑ Ultrasound
- ❑ Measles/viruses
- ❑ Travel
- ❑ Vaccinations
- ❑ Cats
- ❑ Other

Details: _____

Other Diabetes risk factors besides Pregnancy which is considered a risk:

- ❑ Weight is not normal before pregnancy (BM≥25)
- ❑ Ethnic group with high prevalence
- ❑ Diabetes in first degree relative
- ❑ History of abnormal glucose tolerance
- ❑ Poor obstetric outcomes
- ❑ Elevated Cholesterol
- ❑ PCOS
- ❑ High Blood Pressure
- ❑ Coronary Vascular Disease
- ❑ Physical Inactivity
- ❑ Other

Describe your diet:

We mostly eat: _____
We never eat: _____
Allergic to: _____
Specialty diet: _____
How often do you eat fast food? _____

What Exercise Do You Do Regularly: _____

ID#_____

ARKANSAS DEPARTMENT OF HEALTH

Licensed Lay Midwife Disclosure Form

Return on next visit

Client's Printed Name:_____

Client's Address: _____

Street City State Zip Code Phone Number

In compliance with the Rules Governing the Practice of Licensed Lay Midwifery in Arkansas, at the time of acceptance into care, a Licensed Lay Midwife (LLM) must provide the following disclosures in oral and written form:

A. Licensed Lay Midwife Scope of Practice
B. Informed Consent for Licensed Lay Midwifery Care
C. Requirements for Licensed Lay Midwifery Care
D. Risks and Benefits of Home and Hospital Births
E. Emergency Arrangements
F. Plan for Well-Baby Care

A. Licensed Lay Midwife Scope of Practice

The Rules Governing the Practice of Licensed Lay Midwifery in Arkansas require each LLM to provide information on the scope of licensed midwifery practice under these regulations to clients seeking midwifery care. The LLM may provide approved midwifery care only to healthy women, determined to be at low risk for the development of complications of pregnancy or childbirth; and whose outcome of pregnancy is most likely to be the delivery of a healthy newborn and intact placenta. Apprentice midwives and LLM Assistants work under the on-site supervision of the LLM. A person may not practice or offer to act as an LLM in Arkansas unless he/she is licensed by the Arkansas State Board of Health.

The responsibilities of the LLM are specified by the Regulations in regards to:

1. Required prenatal care.
2. Attendance during labor and delivery.
3. Care of the healthy newborn for the first fourteen (14) days of life unless care is transferred to a physician or APRN whose practice includes pediatrics. After fourteen (14) days, the LLM is no longer responsible to provide care except for routine counseling on newborn care and breastfeeding as indicated. The client should seek further care from a physician or an APRN whose practice includes pediatrics. If any abnormality is identified or suspected, including but not limited to a report of an abnormal genetic/metabolic screen or positive antibody screen, the newborn must be sent for medical evaluation as soon as possible but no later than 72 hours.
4. Postpartum care for a minimum of 30 days after delivery.

These would also apply to any arrangements the LLM has in regard to apprentices she is supervising, or arrangements made with other LLMs to attend the birth, if she/he is unavailable.

The LLM is responsible to ensure the client is informed of and understands the need to receive clinical assessments, including laboratory testing; evaluations by a physician, certified nurse midwife (CNM) or

public health maternity clinician; and required visits with the midwife that are mandated by the regulations. The LLM is also responsible for informing the client of the necessary supplies the client will need to acquire for the birth and the newborn (including eye prophylaxis and vitamin K).

LLM providing care _____Deb Phillips, CPM, LLM_____

Licensed in Arkansas since __1988_____

Arkansas LLM License Number ____R88712_____Expiration Date_____9-1-27____

Certified Professional Midwife (CPM) Yes or No (Circle correct response)

Midwifery Bridge Certificate (MBC) Yes or No (Circle correct response)

If CPM, Certification Number ____97040009_____Expiration Date___5-15-27_____

Each statement below is to be read and initialed by the client.

B. Informed Consent

_____I understand that I am retaining the services of __Deb Phillips_____ who is an LLM, not a CNM or a physician.

_____ I understand the LLM *does or does not* (circle correct response) have liability coverage for services provided to someone having a planned home birth.

_____ I understand that the LLM practices in home settings and does not have hospital privileges.

_____ I understand the LLM *does or does not* (circle correct response) have a working relationship with a physician or CNM. If she/he does, they are:

Physician's Name: _____

CNM's Name: ____Cindy Shaw, CNM_____

_____ I understand that if my LLM relies on a hospital emergency room for backup coverage, the physician on duty may not be trained in obstetrics.

_____ I understand the LLM is trained and certified in Cardiopulmonary Resuscitation (CPR) and neonatal resuscitation.

_____ I understand there are conditions that are outside the scope of practice of an LLM that will prevent me from beginning midwifery care. These conditions include, but are not limited to: previous cesarean delivery, multiple gestation, and insulin-dependent diabetes. _____ I understand that there are conditions that are outside the scope of practice of an LLM that will require physician consultation, referral or transfer of care to a physician, CNM or health department clinician, or transport to a hospital. If during the course of my care my LLM informs me that I have a condition indicating the need for a mandatory transfer, I am no longer eligible for a home birth by an LLM. These conditions include but are not limited to: placenta previa in the third trimester, baby's position not vertex at onset of labor, labor prior to thirty-seven (37) weeks gestation, or active herpes lesions at onset of labor.

_____The LLM is responsible to inform and educate me (the client) on these and other potential conditions that preclude care by an LLM.

ID#_____

_____ I understand emergency medical services for myself and my baby may be necessary and a plan for emergency care must be in place for the prenatal, labor, birth and immediate postpartum and immediate newborn periods, as outlined in Section E of this form.

_____I understand my laboratory test results must be reviewed and interpreted by a physician, CNM or ADH clinician.

_____ I understand that the LLM must work in accordance with all applicable laws. The Rules and Regulations Governing the Practice of Midwifery in Arkansas are available online at the Arkansas Department of Health website or by contacting the Arkansas Department of Health. Healthy.Arkansas.gov

C. Requirements for Licensed Lay Midwifery Care

I understand the LLM has protocols as specified in the Rules Governing the Practice of Licensed Lay Midwifery in Arkansas that must be followed concerning care for normal pregnancy, labor, home birth and the postpartum period, and for specific potentially serious medical conditions. The following requirements are my responsibility, as a midwife client, to fulfill:

_____ I must have an initial, and 36 week visit with a private physician or CNM or go to an Arkansas Department of Health Local Health Unit which provides maternity services for a risk assessment, which includes a physical exam and lab work.

_____ If my pregnancy continues beyond 41 weeks, I must have a visit before 42 weeks with a private physician or CNM or go to an Arkansas Department of Health Local Health Unit which provides maternity services for a risk assessment.

_____I must ensure that all my healthcare providers have access to all my medical records at the time of each visit and at the time of delivery. It is unsafe for any of these practitioners to evaluate or deliver a client without knowledge of all lab results and current risk status.

_____ I must have Vitamin K on hand for the birth. This may be ordered in advance of delivery from the Local Health Unit or may be obtained at a pharmacy by prescription.

_____ I must have ophthalmic erythromycin on hand for the birth, if indicated. This may be ordered in advance of delivery from the Local Health Unit or may be obtained at a pharmacy by prescription.

D. Risks and Benefits of Home and Hospital Births

Before becoming a client with the intent of delivery at home, I understand I need to be familiar with some of the advantages and disadvantages of having either a home birth or a hospital birth.

RISKS AND BENEFITS OF HOME AND HOSPITAL BIRTHS		
BENEFITS		
Home	**Hospital**	
☐ Planned home birth with skilled, trained,	☐ Skilled, specialized obstetric staff	3

midwifery care	
Natural progression of labor	Medications to induce or maintain labor, if needed
Non-invasive monitoring of labor progression and fetal well-being	Early detection of fetal distress through advanced monitoring techniques
Privacy and familiar home surroundings	Equipment available for high risk situations: intensive care, resuscitative equipment, surgical suites
Decreased obstetric interventions – midwives are trained to handle some unexpected emergencies on site for low risk women	Immediate medical intervention including medications and blood products if needed, by OB/GYN, pediatrician, and medical personnel trained to deal with life threatening emergencies on site
Preserves family togetherness; provides personalized care; honors client's choices for birthing position, movement, and food and fluids during labor; labor takes place in familiar surroundings	Some hospitals provide family-centered birthing and some provide birthing suites that create a home-like atmosphere and incorporate client's choices into their birth plan
Use of natural, non-invasive pain relief techniques	Availability of pain medications upon request
The absolute risk of a planned home birth may be low	The American College of Obstetrics and Gynecology and the American Academy of Pediatrics state that hospitals and birthing centers are the safest settings for birth in the United States
RISKS	
Home	**Hospital**
A planned home birth is associated with a twofold increased risk of newborn death compared to a hospital birth for low risk mother/infant pairs, and greater increases for those at higher risk.	Hospital births are associated with increased maternal interventions including the possibilities of: epidural analgesia, electronic contraction and fetal heart rate monitoring, IVs, vacuum extraction, episiotomy, and cesarean delivery.
Certain emergency conditions may occur without warning, which cannot be handled in a timely manner at home; and the home may lack needed emergency equipment for advanced resuscitation. In emergency situations greater risk of adverse outcomes exists, including death, for both mother and	Not all hospitals have immediate availability of specialty consultation and care in cases of certain medical emergencies and in these situations there is the risk for adverse outcomes including death for the mother and child.

child.	
▯ Transport time to a hospital in case of an emergency can seriously impact the outcome on health of mother and newborn. Travel time of more than 20 minutes has been associated with increased adverse newborn outcomes, including mortality.	▯ Hospitals that provide delivery services may not be available in some geographic areas requiring the mother to travel longer distances for urgent care of sudden risks.

_____ I have reviewed the above table and have discussed with my midwife the risks and benefits of both home and hospital births.

E. Emergency Arrangements

An emergency plan must be developed between the client and the LLM detailing the arrangements for transport of the client to the nearest hospital licensed to provide maternity services or to the hospital where the back-up physician has privileges. The hospital must be within fifty (50) miles of the home birth site.

1. The licensed physician or CNM that will be consulted when there are deviations from normal in either the mother or infant is:

   a. Name of Clinic/Physician/ADH Clinician/CNM for the mother:

   _____ Phone Number_____

   City/State_____

   b. Name of Physician/ADH Clinician/CNM for the infant if known:

   _____ Phone Number_____

   City/State_____

2. Transport Arrangements: In an emergency, transport to a hospital will be by:

   Ambulance: Name:_____EMS_____

   Phone: _____911_____

   Miles from home birth site:___info. not known_____

   Estimated time to home birth site___info. not known____

   Has the option of using a private vehicle for backup been discussed? ☐ Yes ☐ No

3. In the event of maternal emergency in a home birth, transport will be to the following:

   Hospital:_____

   City/State:_____

   Phone:_____

   Miles from home birth site_____ Estimated Time from home birth site_____

   I understand that the physician on duty in this hospital emergency room may not be trained in obstetrics.

ID#_____

4. In the event of a neonatal emergency requiring immediate transport, transport will be to the **nearest** hospital:

Hospital:_____

City/State:_____

Phone:_____

Miles from home birth site_____ Estimated Time from home birth site_____

I understand that the physician on duty in this hospital emergency room may not be trained in obstetrics or pediatrics.

_____I agree to these arrangements should an emergency or medical complication arise.

F. Plan for Routine Well-baby Care

A plan of care should be developed between the client and a physician or an APRN whose practice includes pediatrics to follow up with routine well-baby visits after birth. The LLM is responsible for newborn care immediately following delivery and for the first fourteen (14) days of life, unless care is transferred before that time. After fourteen (14) days, the LLM is no longer responsible to provide care except for routine counseling on newborn care and breastfeeding as indicated. The client should seek further care from a physician or an APRN whose practice includes pediatrics. If any abnormality is identified or suspected, including but not limited to a report of an abnormal genetic/metabolic screen or positive antibody screen, the newborn must be sent for medical evaluation as soon as possible but no later than 72 hours.

Name of Physician/APRN for the infant: _____ Unknown: ☐

Phone Number_____ City/State_____

G. Consent Signatures

The consent signatures page will be kept in the client's chart as proof that all above Disclosure Form items have been initialed.

I have discussed and provided in writing the information included in this disclosure form with my client. I have discussed with her how this impacts her pregnancy and its outcome.

LLM Signature:_____ Date Signed_____

The above information has been discussed with me and also provided in writing. I understand its implications to my pregnancy and its outcome.

_____
Client Printed Name

_____ _____
Client Signature Date Signed

ID#_____

Media Release

I do hereby authorize that Deb Phillips, CPM, LLM may speak of me.
She may use my birth story to educate women about natural childbirth and midwifery care especially to students, other clients and in childbirth classes.
She will not "out" my baby on social media but will make sure that the family does so first.
She may say that she is on the way to a birth and that it was a boy/girl without specified permission.
I am aware that students or Health Department will be seeing my health information.

Texting is a very easy way to get your questions answered. Protected Health Information should not be sent by text. But you may discuss whatever you wish and ask questions at will.

Client:_____Date: _____

Payment Agreement

I agree to pay the midwife fee before the birth of my baby. I understand that I can make payments during my pregnancy. If I do not end up having a home birth but did make it to the ninth month, the entire fee is due. The split fee for Prenatal Care is $3000, Birth and Postpartum is $2000. Labs, pool liner, herbs and supplies are extra. Risk Assessments with Cindy Shaw, CNM are extra. At least 2 students will accompany me to all births.

_____ _____
Client Date

ID#_____