



ARIZONA DEPARTMENT OF HEALTH SERVICES  
Physician Consultation for an At-Home Delivery

PHYSICIAN INFORMATION

Name: _____	
Arizona License Number: _____	Type: <input type="checkbox"/> MD <input type="checkbox"/> DO
Office Address: _____	
Telephone Number: _____	Email Address: _____

REFERRING MIDWIFE'S INFORMATION ON FILE WITH DEPARTMENT

Name: _____	Telephone: _____
License Number: _____	Email Address: _____

CLIENT INFORMATION

Name: _____	Telephone: _____	Consultation: <input type="checkbox"/> In person <input type="checkbox"/> Telephone <input type="checkbox"/> Electronic	
G/P: _____	EDC: _____	WGA: _____	Date of Birth: _____

CHECK ONE OR MORE BOXES TO INDICATE PATIENT'S MEDICAL CONDITION

<input type="checkbox"/> PREVIOUS CESAREAN SECTION	
<input type="checkbox"/> No classical/vertical uterine incision	<input type="checkbox"/> Reason for previous Cesarean section: _____
<input type="checkbox"/> >18 months since last Cesarean section	
<input type="checkbox"/> Number of Cesarean sections: _____	<input type="checkbox"/> Successful VBAC since last Cesarean section
<input type="checkbox"/> MULTIPLE GESTATION	
<input type="checkbox"/> No more than 2 fetuses	Documented ultrasound confirmation of: <input type="checkbox"/> dichorionic/diamniotic twins <input type="checkbox"/> normal growth of both twins
<input type="checkbox"/> BREECH	



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I, \_\_\_\_\_, PRINT PHYSICIAN NAME:

- Have conducted an in-person, telephonic or electronic discussion with the client prior to 30 weeks gestational age and appropriate to the client's specific condition.

YES [ ] NO [ ] Date of Consultation: \_\_\_\_\_ Initial: \_\_\_\_\_

- Have reviewed the client's medical records related to the current pregnancy, including medical records from previous pregnancies, if history of cesarean section.

YES [ ] NO [ ] Initial: \_\_\_\_\_

- Have explained the potential risks, adverse outcomes, and alternatives to a home birth associated with their specific condition to the client, including the need for emergency transport, surgical intervention, and the potential for neonatal and maternal complications and/or death.

YES [ ] NO [ ] Initial: \_\_\_\_\_

- Have reviewed the midwife's emergency action plan developed for this client. I understand that reviewing the plan does not make me responsible for providing care for this client.

YES [ ] NO [ ] Initial: \_\_\_\_\_

PHYSICIAN RECOMMENDATION:

- This client is appropriate for an at-home delivery. YES [ ] NO [ ] Initial: \_\_\_\_\_

PHYSICIAN'S ATTESTATION

I, \_\_\_\_\_, (PRINT PHYSICIAN NAME) attest that the information provided on this form is true and correct. I understand that I am not approving or denying an at-home delivery for this client, and that the client may decide to proceed with an at-home delivery regardless of my recommendation. I understand that I am not responsible for the care, management or outcomes for the pregnancy or delivery of this client or her fetus, unless I agree to take over management of her care.

Physician's Signature

Date Signed



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CLIENT'S ATTESTATION

CLIENT INFORMATION

Name: _____	Date of Birth: _____
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REFERRING MIDWIFE'S INFORMATION ON FILE WITH DEPARTMENT

Name: _____	
Telephone: _____	License Number: _____

CONSULTING PHYSICIAN INFORMATION

Name: _____
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I, \_\_\_\_\_, (PRINT CLIENT'S NAME) consulted with a physician and the potential risks, adverse outcomes, and alternatives to a home birth associated with my specific condition, including the need for emergency transport, surgical intervention, and the potential for neonatal and maternal complications and/or death have been discussed with me. Initial: \_\_\_\_\_

I understand I may decide to proceed with an at-home delivery, despite the physician's consultation. Initial: \_\_\_\_\_

I acknowledge that this physician is not responsible for the care, management or outcomes for my pregnancy or delivery of my fetus, should I decide to proceed with an at-home delivery. Initial: \_\_\_\_\_

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date Signed