

Sample Consent Forms

Extracted from
2006 CRICO/RMF Guidelines for Obstetrical Providers

Contents

Appendix A: [Care During Labor and Birth](#)

Appendix B: [Breech Version or External Cephalic Version](#)

Appendix C: [Delivery Following a Previous Cesarean](#)

Appendix D: [The Delivery of Twins](#)

Appendix E: [Primary Cesarean Section on Maternal Request](#)

Appendix A

About Your Care During Labor and Birth

Having a baby is a natural event. Most mothers and babies go through labor and birth without serious problems. Even so, certain situations may arise near the end of your pregnancy or in labor that can affect the care you or your baby need.

Described below are some of those situations. This form also includes some common practices you might experience during your time at the hospital. If you have questions, be sure to ask your clinician.

Labor

- 1) A nurse will work with your doctor or midwife to take care of you. In some hospitals, doctors training in obstetrics or anesthesia (residents) may also help care for you.
- 2) Other clinicians-in-training (i.e. medical students, student midwives, nurse, or physician assistants) may be involved in caring for you. Students are always supervised by your doctor, midwife, or nurse.
- 3) You may have a blood test during labor to measure your blood count, or for other purposes.
- 4) When you arrive at the hospital in labor, usually, a nurse will put a fetal monitor on your abdomen to check the baby's heartbeat. If the heartbeat is reassuring, the monitor may be removed. The baby's heartbeat will then be checked from time to time during the labor.
- 5) Sometimes a baby's heartbeat needs to be checked more closely and a mother will wear a fetal monitor on her abdomen for part or all of labor. Sometimes there are variations in the fetal heart rate pattern that cause concern, even when the baby is fine. Studies have shown that these patterns are difficult to interpret and may lead to an increased chance of cesarean or forceps delivery. Fetal monitoring does not prevent cerebral palsy or birth defects.
- 6) In certain situations, more information about the baby's condition is needed than can be obtained from the external monitor. If this happens, your doctor or midwife will place an internal monitor electrode on the baby's head. Infrequently, this can cause infection of the baby's scalp.
- 7) In some cases (less than 0.5 percent) the doctor or midwife needs a blood sample from the baby's scalp to find out more about how the baby is tolerating labor. The sampling is like having your finger pricked. On rare occasions, the area from which the sample is taken will bleed or get infected.
- 8) Sometimes non-reassuring patterns in the baby's heart tracing can be corrected by an amnioinfusion. In this procedure, the clinician places a small plastic tube into the uterus and fluid is added to the amniotic fluid. This may take pressure off the umbilical cord in some situations.
- 9) You may have an intravenous line (iv) during labor to supply extra fluids and/or provide certain types of pain relief medications or antibiotics. Not all women require an iv.
- 10) There are many forms of pain relief for labor such as walking, use of the bathtub or shower, breathing and deep relaxation techniques, and massage. If you feel you need additional pain relief, your doctor or midwife can offer you other choices that are safe for you and your baby. These include:

Medication: You can be given a medication as a shot or through an iv line. You might get a little drowsy. Allergic reactions are infrequent, but can happen.

Epidural: An epidural is the most common form of pain relief for labor and birth. An anesthesia specialist will place a thin flexible tube in your back. This procedure will take about 20 minutes. You can then receive pain relief medication through the tube. This will diminish most of the pain of labor.
- 11) If your labor slows down, your doctor or midwife might give you the hormone-like drug oxytocin (Pitocin®) through an iv to make your contractions stronger and closer together.
- 12) Sometimes, before a woman starts labor on her own, her health or the health of her baby makes it necessary for labor to be induced. In the United States, about a quarter of labors are induced. Some reasons for induction of labor include a baby that is overdue by more than a week or two, a baby which has not grown well, infection, high blood pressure, diabetes, or a rupture of the bag of waters. Your doctor or midwife can help get labor started in various ways. If your cervix is soft and stretchy, oxytocin (Pitocin®) given through an iv will most commonly be used. If your cervix is not ripe, medications called prostaglandins are usually given first.
- 13) Induction has certain risks including creating contractions that are too strong or too frequent, which can stress the baby. In almost all situations, this risk is manageable and the contractions can be decreased.

Vaginal Birth

- 1) Labor contractions slowly open the cervix. When the 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, followed by the rest of the body.
- 2) About 10–15 percent of mothers need some help getting the baby through the birth canal. A doctor or midwife may apply a special vacuum cup or forceps to the baby's head to help the mother push the baby out. Large studies have shown that the vacuum cup and forceps are safe.
- 3) In approximately one percent of births, the shoulders do not come out easily, a condition called shoulder dystocia. If this happens, your doctor or midwife will try to help free the baby's shoulders. Shoulder dystocia may cause a broken collar bone or arm for the baby or nerve damage to the baby's arm. Most often, these problems heal quickly, but in some instances, the damage and disability is permanent. Shoulder dystocia may cause tears around the vaginal opening as the baby delivers or additional bleeding after birth.
- 4) Many women will get small tears around the vaginal opening. Sometimes a doctor or midwife will cut some tissue to make the opening bigger (episiotomy).
- 5) Most women with tears or an episiotomy will need stitches. The stitches will dissolve over a few weeks during the process of healing. Infrequently, an episiotomy or tear can extend into the rectum. The area may be swollen and sore for a few days, but usually heals without problems. Infection of the episiotomy or tear occurs infrequently.
- 6) Normally, the uterus will expel the placenta soon after birth. In about one percent of births, this doesn't happen and the doctor or midwife must reach into the uterus and remove the placenta. If this happens, you may need anesthesia so he or she can remove the placenta.
- 7) All women lose some blood during childbirth. A woman is more likely to lose a lot of blood if:
 - the placenta doesn't pass on its own,
 - she is having twins or triplets, or
 - labor lasts a very long time.
- 8) Oxytocin (Pitocin®) can help reduce bleeding after birth. If bleeding is very heavy, other medications may be used to help contract the uterus. Very few women (less than one percent) need a blood transfusion after vaginal birth.

Cesarean Section

- 1) Approximately one third of mothers give birth by cesarean. Some cesareans are planned, while others are unexpected.
- 2) During cesarean birth, a doctor delivers the baby through an incision in the mother's abdomen.
- 3) The most common reasons for cesarean birth are:
 - the cervix doesn't open completely,
 - the baby doesn't move down the birth canal,
 - the baby needs to be delivered quickly because of a problem for mother or baby, and
 - the baby is not in a position that allows for a vaginal delivery.
- 4) Anesthesia is always used for a cesarean section. Close to 95 percent are performed using spinal or epidural technique, so the mother is awake during the procedure. About five percent of cesarean sections are performed using general anesthesia.
- 5) Blood loss is greater with cesarean birth than with a vaginal birth; the need for a transfusion is infrequent (12 in 1,000).
- 6) Infection is more common after cesarean birth. Often, doctors give antibiotics during the birth to help prevent this.
- 7) A thin tube called a catheter will drain the bladder during the operation. It will usually remain in place for 12–24 hours afterwards.
- 8) In less than one percent of cesarean sections, the operation may cause damage to the bowel or urinary system. Most of the time these problems will be recognized and corrected during the operation.
- 9) In less than one percent of cesarean sections, the baby might be injured during the birth. When this does happen, it is usually minor.

After Birth

- 1) The chance of uterine infection after a vaginal birth is 2–3 percent; after cesarean birth, the chance of uterine infection is 20–30 percent. Antibiotics can lower the risk, but won't guarantee that you won't get an infection.
- 2) You may have cramps as the uterus returns to its normal size. This cramping gets stronger with each birth. You may notice it more when breast feeding.
- 3) If your baby is delivered vaginally, you will probably have discomfort around the vaginal opening. If you have a cesarean birth, you will have pain from the incision in your abdomen. Ask your doctor or midwife for pain relief if you need it.

- 4) Vaginal bleeding is normal after birth. It will lessen over 1–2 weeks. About one percent of women have heavy bleeding and need treatment. Sometimes, this type of bleeding can happen weeks after birth.
- 5) Most women feel tired and weepy after birth. For about ten percent of new mothers, these feelings don't go away... or get worse. If this happens, ask your doctor or midwife for help.
- 6) Various factors influence when you go home from the hospital. These include your health, your baby's health, and the support you have at home.

Newborn

- 1) At one and five minutes after birth, the baby will be assigned Apgar scores. The scores measure the baby's heart rate, breathing, color, muscle tone, and vigor. These scores assist your pediatrician and the nursery staff in planning the care of your baby.
- 2) About 3–4 percent of babies are born with birth defects. Many do not hurt the baby (such as extra fingers or toes). Some, such as some heart abnormalities, can be serious.
- 3) Approximately 7–10 percent of babies are born before term (less than 37 weeks of pregnancy), or have a problem that will require some form of special care. Approximately six percent of all newborn babies require treatment in a Special Care Nursery (Level II nursery) and three percent require admission to a Neonatal Intensive Care Unit (Level III nursery).
- 4) About 12–16 percent of babies pass meconium (the first bowel movement) into the amniotic fluid before delivery. When this occurs, the baby's mouth and airway will be suctioned at the time of delivery to remove as much of the meconium as possible.
- 5) After your baby is born, he or she will be given eye ointment to prevent infection of the eyes and an injection of Vitamin K to prevent bleeding. Using only a few drops of blood from his or her heel, tests will be done to screen your baby for 29 different diseases. The results will be sent to your pediatrician. Your baby's hearing will be checked while in the hospital. You will also be encouraged to have your baby receive the first immunization against hepatitis B before going home.
- 6) Three to four of every 1,000 newborns have serious bacterial infections of the blood, lungs, and—in rare cases—the surface of the brain and spinal cord. If you carry Group B Strep, develop a fever during labor, or if your membranes (bag of waters) are ruptured for a long time, you may be given antibiotics during your labor to reduce the risk of infection to your baby.

If your baby is at increased risk of infection or shows signs of infection, your pediatrician may decide to send blood or cultures to the laboratory for analysis. Your baby may also receive antibiotics.

Infrequent or Rare Events

The following problems occur infrequently or rarely during pregnancy:

- 1) A few babies are born too early to survive, or have serious medical problems. About 7–10 out of 1,000 babies die in late pregnancy (stillbirth) or soon after birth.
- 2) About 3 out of every 1,000 mothers develop blood clots in their legs after giving birth, and require treatment. This is more likely to occur after a cesarean section than after a vaginal birth.
- 3) In about 1–2 out of 1,000 births, a doctor must remove the uterus (hysterectomy) to stop heavy, uncontrollable bleeding. This means the woman cannot become pregnant again.
- 4) About 6 out of every 1,000 women receive blood transfusion after giving birth. The risks associated with blood transfusion include 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) Very rarely (less than 1 in 10,000), mothers don't survive childbirth. Causes might include extremely severe bleeding, high blood pressure, blood clots in the lungs, and problems caused by other medical conditions.

Summary

Most babies are born healthy and most mothers go through labor and birth without serious problems. You should realize though, that pregnancy and childbirth have some risks. Many of the possible problems sound very frightening. Remember, most of these problems are uncommon, and the most serious events are infrequent or rare.

Your health care team will watch carefully for signs of possible problems. They will do their best to identify them early, explain them, and offer you treatment. Your health care team looks forward to caring for you during labor and birth, and to delivering a healthy baby.

Authorization for Obstetrical Care

- I have read *About Your Care During Labor and Birth*.
- I understand what has been discussed with me, as well as the content of this form.
- I have been given the opportunity to ask questions and have received satisfactory answers.
- I understand that no guarantees or promises have been made to me about expected results of this pregnancy. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.
- 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.

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

Clinician Name (print)

Date

Clinician Signature

Date

Initials

I refuse blood transfusion under any circumstances and have signed a separate form specifically for the refusal of blood products.

Appendix B

Breech Version or External Cephalic Version

A Breech Version or External Cephalic Version may be an option for a woman whose baby is in the breech (or buttocks down) position late in pregnancy. This procedure allows the clinician to try to turn the baby from breech down to the more usual (head down) position.

About four percent of babies are in the breech position after 37 weeks gestation. This position causes some increased risk for the baby and a slightly higher than average chance of birth trauma. The mother has a high chance of cesarean section. For these reasons, the clinician and mother may elect to try to turn the baby.

This procedure is carried out in the hospital. An ultrasound is used to verify the baby's position and to help the clinician decide what direction to push on your abdomen. The baby's well being is evaluated with an external fetal monitor. A medication may be given by injection to help the uterine muscle relax. Often, the medication makes your heart beat faster and, occasionally, can cause brief palpitations. After these preparations are complete, the clinician will push on the baby through your abdominal wall in an attempt to turn it.

After the procedure, fetal well being is again evaluated with the fetal monitor. If you are Rh negative, Rh immune globulin is usually administered at this time as well.

About 50 percent of the time, the baby can be turned into the head down position. In the other 50 percent, the baby remains breech. Most babies that turn stay head down, however, some may turn back to breech.

If successful, this procedure reduces the chance of cesarean-section delivery, but it is associated with a number of risks:

- During the turning, the baby's heart rate may fall. This is not uncommon and the heart rate usually quickly returns to normal.
- The procedure may cause the onset of labor or cause the membranes to rupture. For this reason, breech version is usually performed within a few weeks of the due date, when the baby should be mature.
- Infrequently (in less than one percent of cases) the baby can be entangled in the cord by the turning.
- Infrequently (in less than 0.5 percent of cases) the placenta may separate from the wall of the uterus. If this happens, the blood flow to the baby is reduced, which can be dangerous for the baby.
- If a problem does occur, an emergency cesarean section may be needed to deliver the baby quickly. Infrequently, a problem will happen several hours or days after the version.
- In very rare instances, the baby can die.

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, as well as the content of this form.
- I have been given the opportunity to ask questions and have received satisfactory answers.
- I understand that no guarantees or promises have been made to me about expected results of this pregnancy. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.
- 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.

I consent to breech version (external cephalic version).

Patient Name (print)

DOB or Patient ID#:

Patient Signature

Date

Clinician Name (print)

Date

Clinician Signature

Date

Initials

I refuse blood transfusion under any circumstances and have signed a separate form specifically for the refusal of blood products.

Appendix C

Delivery Following a Previous Cesarean Section

If you have had one baby by cesarean section, you may have some questions about what happens in the next pregnancy. Each woman who has previously delivered by cesarean section must discuss the situation with her clinicians and decide to either A) plan a repeat cesarean or B) plan a trial of labor with the goal of vaginal delivery. Both options have risks and benefits. This information is intended to summarize the issues for you and will also serve as your consent.

Who is a Candidate for a Trial of Labor?

- 1) When a cesarean section is done, an incision is made in the uterus. If this incision is sideways (transverse) in the lower part of the uterus, the scar is usually strong and the risk of rupture of the scar during labor is low.
- 2) Most women who have had one previous cesarean section with the transverse incision are candidates for a trial of labor in their next pregnancy. Some women with more than one previous cesarean can consider vaginal delivery, but the risk of rupture of the scar goes up with the number of cesarean sections.
- 3) Some women have an incision in the lower part of the uterus, but positioned up and down (vertical). Vaginal delivery can be considered, but the risk of rupture of the scar is higher than for transverse scars.
- 4) Some women have “classical” incisions (a vertical incision in the upper part of the uterus). The risk of complications is higher in this situation. For this reason, vaginal birth is not recommended after a classical incision.
- 5) Your clinician will review the records from your last cesarean(s) to verify the incision type(s). If your records are unavailable, your clinician will not be able to determine what type of incision you had; the two of you will have to decide how to proceed without that information.

What Else is Needed for a Trial of Labor?

The following other needs should be met before you and your clinician decide on a trial of labor:

- 1) your pelvis should be judged adequate,
- 2) you should have no other uterine scars, and
- 3) the obstetrician and other personnel must be immediately available should an emergency cesarean section be required.

How Successful is a Trial of Labor?

- 1) Between 60–80 percent of women who have a trial of labor for delivery will give birth vaginally. Even those who have had two cesareans demonstrated a relatively high success rate with a vaginal delivery.
- 2) Some studies show that the success rate for a trial of labor declines if the baby is big (40 percent for babies 10 lbs. or larger). Success rates may also be lower for women who had their first cesarean section done for arrest of labor.

What are the Benefits and Risks of a Vaginal Birth?

- 1) If the trial of labor results in a vaginal birth, the mother usually has a faster recovery time, shorter hospital stay, decreased discomfort, less chance of blood transfusion, less chance of postpartum infection, and the risks of major surgery (cesarean section) are avoided. Vaginal birth also reduces the risk of respiratory difficulty for the newborn in the first few hours of life.
- 2) If a trial of labor is not successful, however, a cesarean will be needed again. Unplanned cesarean sections have more risk for both mother and baby than a planned cesarean. This includes a higher chance of postpartum infection, blood transfusion, and uterine rupture.
- 3) Uterine rupture can occur after a previous cesarean section. This rupture can occur during pregnancy or labor. The risk of uterine rupture of a low transverse uterine incision is less than one percent. Should a rupture occur, an emergency cesarean section is needed. The baby may be injured or die from this rupture. Occasionally, the uterus cannot be repaired and a hysterectomy (removal of the uterus) could result. Rarely, other organs such as the bladder or bowel may be injured from a uterine rupture or emergency cesarean section.
- 4) The risk for rupture of the scar also goes up if the labor is induced, especially if the 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 section, is not well studied.

What Are the Benefits and Risks of a Scheduled Repeat Cesarean Section?

- 1) A repeat cesarean section can be planned and the date selected. The mother avoids any chance of a long labor followed by another cesarean section. The risks of an attempted vaginal delivery are avoided.
- 2) The most common complication associated with cesarean sections is infection. The infection rate is higher in women who are delivered by cesarean section than for women who have vaginal births.
- 3) Blood loss is usually greater with a cesarean than with a vaginal delivery. Approximately 12 in 1,000 of all women having cesarean sections require blood transfusion.
- 4) Injury to the urinary system occurs in less than 1 in 200 women. These problems are usually identified and repaired at the time of the cesarean section.
- 5) Injury to the bowel (the intestines, colon, or rectum) is rare, occurring in fewer than 1 in 1,000 cesarean deliveries. If an

injury to the bowel occurs, it will usually be recognized and corrected at the time of the cesarean section.

- 6) Rarely, infertility may result from the adhesion formation (internal scar tissue).
- 7) Rarely, a hysterectomy can be required.

Who Should Not Try Labor and Vaginal Delivery?

For some women, the risks of a trial of labor following a previous cesarean section clearly outweigh the benefits.

This includes women with:

- previous classical cesarean section;
- some previous uterine surgery, including some myomectomies;
- more than two previous cesareans;
- a too small pelvis; or
- medical or obstetrical problems that prevent vaginal delivery.

Authorization for Delivery Following a Previous Cesarean Section

- I have read *Delivery Following a Previous Cesarean Section*.
- I understand what has been discussed with me, as well as the content of this form.
- I have been given the opportunity to ask questions and have received satisfactory answers.
- I understand that no guarantees or promises have been made to me about expected results of this pregnancy. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.
- 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.

I have chosen to attempt a trial of labor and vaginal delivery.

Patient Name (print)

DOB or Patient ID#:

Patient Signature

Date

Clinician Name (print)

Date

Clinician Signature

Date

Initials

I refuse blood transfusion under any circumstances and have signed a separate form specifically for the refusal of blood products.

I have chosen to forgo a trial of labor and deliver via cesarean section.

Patient Name (print)

DOB or Patient ID#:

Patient Signature

Date

Clinician Name (print)

Date

Clinician Signature

Date

Initials

I refuse blood transfusion under any circumstances and have signed a separate form specifically for the refusal of blood products.

Appendix D

The Delivery of Twins

The following information is provided to give you an idea of possible events and risks related to the labor and delivery period for a pregnancy with twins.

Timing of Delivery

- 1) Approximately 40 percent of twin pregnancies enter labor early.
- 2) Sometimes, medical complications require early delivery.
- 3) Almost all women with twins are delivered before or by their due dates.

Route of Delivery

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

- 1) Vertex/Vertex: both babies are head down. Vaginal delivery of both babies is (usually) recommended.
- 2) Non-vertex Presenting Twin: the first baby is not head down. Cesarean-section delivery is generally recommended.
- 3) Vertex/Non-vertex Twins: the first baby is head down and the second is lying either buttocks down (breech) or sideways. The best approach to this complex situation is unclear. The options include:

- cesarean delivery of both twins;
- vaginal delivery of the first baby, followed by an attempt to turn the second baby;
- vaginal delivery of the first baby, followed by breech vaginal delivery of the second baby; or
- vaginal delivery of the first baby, followed by cesarean delivery of the second baby (an uncommon situation that usually results from a complication during attempted vaginal delivery of the second baby).

Each approach has risks. Vaginal delivery poses additional risks for the second twin, including the risk of birth trauma. A cesarean section, which may be unavoidable even if a vaginal delivery is desired, includes the risk of bleeding, infection, and surgical injury to the bowel or bladder.

In some situations, vaginal breech delivery of the second twin is not recommended:

- the second baby is estimated to be considerable larger than the first,
- the 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).

Authorization for Twin Delivery

- I have read *The Delivery of Twins*.
- I understand what has been discussed with me, as well as the content of this form.
- I have been given the opportunity to ask questions and have received satisfactory answers.
- I understand that no guarantees or promises have been made to me about expected results of this pregnancy. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.
- 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.

I consent to obstetrical care.

Patient Name (print)

DOB or Patient ID#:

Patient Signature

Date

Clinician Name (print)

Date

Clinician Signature

Date

Initials

I refuse blood transfusion under any circumstances and have signed a separate form specifically for the refusal of blood products.

Appendix E

Primary Cesarean Section on Maternal Request

Occasionally, a woman will request a primary (first time) cesarean section without a medical indication. This information summarizes the issues and also serves as your consent.

What Are the Benefits and Risks of a Primary Cesarean Section on Maternal Request?

- 1) A cesarean section can be planned and the date selected. The mother avoids any chance of a long labor followed by a cesarean section. The risks of a vaginal delivery are avoided.
- 2) The most common complication associated with a cesarean section is infection. The infection rate is higher in women who are delivered by cesarean section than for women who have vaginal births.
- 3) Blood loss is usually greater with a cesarean section than with a vaginal delivery. Approximately 12 in 1,000 of all women having a cesarean section require blood transfusion.
- 4) Injury to the bladder or ureters (the urinary system) occurs in less than 1 in 200 women. These problems are usually identified and repaired at the time of the cesarean section.
- 5) Injury to the bowel (the intestines, colon, or rectum) is rare, occurring in less than 1 in 1,000 cesarean sections. If an injury to the bowel occurs, it will usually be recognized and corrected at the time of the cesarean section.
- 6) Delivering a baby by cesarean section can lead to serious problems in future pregnancies. Occasionally, after cesarean section, 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 as more cesarean sections are performed.
- 7) Once one pregnancy has been delivered by cesarean section, the chance of cesarean section in the next pregnancy increases. With each subsequent surgery, there is a higher risk of scarring and possibly increase in difficulty of the surgery. There is also an increased risk for rupture of the uterus in subsequent pregnancies if labor occurs.
- 8) Rarely, infertility or chronic pelvic pain may result from the formation of scar tissue (adhesions).
- 9) Rarely, a hysterectomy may be needed.

Authorization for Primary Cesarean Section on Maternal Request

- I understand that I have the option for vaginal delivery and that I do not have specific medical indications for cesarean section.
- I have read *Primary Cesarean Section on Maternal Request* and *About Your Care During Labor and Delivery*.
- I understand what has been discussed with me, as well as the content of this form.
- I have been given the opportunity to ask questions and have received satisfactory answers.
- I understand that no guarantees or promises have been made to me about expected results of this pregnancy. Ongoing discussion(s) about my current status and the recommended steps will be a part of my care.
- 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.

I request and consent to primary cesarean section.

Patient Name (print)

DOB or Patient ID#:

Patient Signature

Date

Clinician Name (print)

Date

Clinician Signature

Date

Initials

I refuse blood transfusion under any circumstances and have signed a separate form specifically for the refusal of blood products.