NATIONAL MIDWIFERY GUIDELINES FOR CONSULTATION AND REFERRAL

5TH EDITION

Australian College of Midwives

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(5th Edition)

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The Australian College of Midwives (ACM) affirms that inclusivity is fundamental to safe, respectful and high-quality midwifery care.
Woman-centred care is inclusive of the woman, partner, wider family, fetus and newborn, and covers healthy and complex pregnancies and births.
ACM recognises that some individuals have diverse gender identities and supports inclusive language that respects gender diversity, such as pregnant person, childbearing people and parent, while affirming the continued and central use of the terms woman, mother and maternity in recognition of women's lived realities and ongoing gender-based inequality.
ACM recognises that the majority of people who become pregnant and give birth worldwide identify as women.
Midwifery philosophy is founded on being 'with woman' and the provision of individualised woman-centred care and is intended to be inclusive of all individuals accessing midwifery care.

Scan the QR code for all Australian College of Midwives position statements.

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1 INTRODUCTION

The Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral 5th edition (the Guidelines) have been designed to support collaborative decision-making and care integration. The Guidelines are designed for midwives, medical practitioners and healthcare providers working across all models of maternity care in public and private health services and midwives working in private practice. While the Guidelines do not prescribe birth location, they provide a valuable framework for ensuring safe, informed, and coordinated care across all maternity models and settings including community, hospital and home.

Purpose of the Guidelines

- Provide holistic, woman-centred care
- Guide evidence-based decision-making
- Facilitate timely discussion, consultation, and referral
- Support multi-disciplinary collaboration and seamless coordination of care
- Enable midwives to work to their full scope of practice

Social indications

ACM recognise that social factors have a significant impact on the health and well-being of the woman, baby and family. The 5th edition has been updated to remove the 'social indications' section as screening and assessment of social factors lies within the scope of midwifery practice. A midwife is educated to respond to and engage additional support services as required. This includes early detection of social indications that may impact parents-to-be and their baby and the organisation of systematic, preventive health and social work interventions to support all families as required.

Acknowledgement

ACM would like to acknowledge and extend its sincere appreciation to all contributors to previous editions of the Guidelines. ACM would also like to thank the midwives, medical practitioners, other healthcare providers, and consumers who generously contributed their time, expertise, and insights to the review and development of the 5th edition of the Guidelines. Your commitment to ensuring the highest standards of practice is deeply valued. This edition reflects the dedication of all who participated in its review. (Please refer to Appendix C: Acknowledgements)

Dr Alison (Ali) Teate, President
Australian College of Midwives
February 2026

2 STANDARDS OF PRACTICE

2.1 Professional standards

Midwives work within the Nursing and Midwifery Board of Australia's (NMBA):

- Midwife standards for practice – providing a framework for midwifery practice in all contexts[1]
- Decision-making framework for midwifery practice – to ensure safe professional practice[2]
- Safety and quality guidelines for privately practicing midwives – a regulatory framework to support the safe, professional practice of Privately Practising Midwives (PPMs)[3]
- Code of conduct for midwives[4]
- International code of ethics for midwives[5]

2.2 Scope of practice

The scope of an individual midwife's practice will vary depending on the context in which the midwife works, the health needs of women and the baby or babies, the level of competence and confidence of the midwife and the policy requirements of the service provider.[1]

Midwives may also have additional qualifications and should be supported to work to their full scope of practice.[6] This may include but is not limited to:

- Endorsement to prescribe scheduled medicines
- International Board Certified Lactation Consultant® (IBCLC®)
- Maternal, Child and Family Health

3 GUIDING PRINCIPLES

3.1 Respectful maternity care

- Recognises a woman's right to autonomy, choice of birthplace and to be treated with dignity and respect. The right to information, informed consent, and respect for their choices and preferences, including declining recommended care.
- Requires all healthcare providers to act with integrity and accountability, and respect each woman's right to self-determination and autonomous decision-making.[7-10]
- Woman-centred, culturally safe and responsive, and trauma-informed care embedded in every interaction across the continuum of care.

3.2 Woman-centred care

- The woman is at the centre of all discussions and decisions.[11]
- Woman-centred care is inclusive of the partner, wider family, fetus and newborn.
- Ensure the use and interpretation of the Guidelines support informed decision-making and respectful care.
- Provide culturally safe and responsive maternity care for all women.

3.3 Cultural safety

- Is determined by Aboriginal and Torres Strait Islander individuals, families and communities.[12]
- Requires recognition of the ongoing impacts of colonisation, racism, and systemic inequities, and a commitment to care that is respectful, empowering, and free from cultural harm.[12]
- Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.[12]

3.4 Culturally responsive care

- Is a principle that applies to all women and families, regardless of cultural background. It ensures that maternity care environments are respectful, inclusive, and responsive to diverse values, beliefs, and experiences, so that every woman feels safe and supported.[13]

3.5 Trauma informed care

- Acknowledges that past trauma can influence pregnancy and birth, with a focus on providing a safe, supportive environment that respects a woman's autonomy, choice, and control to prevent trauma or re-traumatisation.

3.6 Continuity of carer

- Promote opportunities for women to be cared for by a known and trusted midwife across the continuum of care while recognising that different models of care may be available in different settings.
- Where a decision is made for the medical practitioner to be the clinical lead, the primary midwife will continue to provide midwifery care as part of the collaborative team.

3.7 Informed decision making

- Care is to be provided in accordance with the principles of informed consent and decision-making.[14]
- At the commencement of care, the midwife outlines their scope of midwifery care to the woman and where relevant, the partner and family. This will include an explanation of how the Guidelines inform the provision of care and decision making.
- Provide the woman with user-friendly information to facilitate informed consent for any recommendation of care. Sufficient time is required for the woman to:
    - consider the recommendation/s
    - ask any questions and seek clarification and
    - make an informed decision.
- The woman is free to accept or decline any recommendation of care and/or request a second opinion.
- When a woman exercises a choice to decline recommended care, please see:
    - 6.5: Declining a consultation or referral
    - Section 10: When a woman chooses to decline recommended care
    - Appendix A: Record of understanding

4 STRUCTURE OF THE GUIDELINES

The Guidelines are designed to support midwives to identify clinical indications that may require additional input from other healthcare providers.

The Guidelines are organised into three sections:

- Section 7: Clinical indications developed prior to or during the antenatal period
- Section 8: Clinical indications during the intrapartum period
- Section 9: Clinical indications during the postnatal period

Each section contains reference tables that list specific conditions or circumstances that a woman and/or the fetus/baby may present with. The tables provide a recommended guidance level to assist midwives and healthcare providers in planning appropriate care pathways.

5 THREE LEVELS OF GUIDANCE: DISCUSS, CONSULT & REFER

When a condition or circumstance is identified during care, it is recommended that the midwife use their clinical judgement, consider their scope of practice and the following guidance to determine the appropriate level of consultation and/or referral. The primary midwife is well positioned to maintain their role in providing care to the woman, working in partnership and collaboration with healthcare providers, irrespective of the consultation or referral level.

Table 5.1 Levels and care provider responsibilities

Level	Description	Care provider with primary responsibility
A	Discuss	The midwife may choose to discuss care with a midwifery colleague, medical practitioner, and/or other healthcare provider/s if indicated. (Refer to 6.2) **Lead care provider:** The midwife will provide and coordinate care.
B	Consult	Consultation with a medical practitioner for additional planning, input/advice is usually warranted. Consultation with other additional healthcare provider/s may be appropriate depending on the indication. (Refer to 6.3) **Lead care provider:** The midwife will continue to provide and coordinate care in consultation with the medical practitioner and/or other healthcare provider/s.
C	Refer	Referral to a medical practitioner for management of care is warranted. Referral to other additional healthcare provider/s may be appropriate depending on the indication. (Refer to 6.4) **Lead care provider:** Where a decision is made following referral for the medical practitioner to be the clinical lead, the midwife will continue to provide midwifery care in collaboration with the medical practitioner and other healthcare provider/s as required. The clinical lead care role may be transferred back to the midwife if the condition permits.

6 EXPLANATORY NOTES: DISCUSS, CONSULT & REFER

6.1 Considerations for all levels of guidance (A/B/C)

6.1.1 It is the midwife's responsibility at the commencement of care to seek clinically relevant information, understand the woman's needs and preferences and to explain the process of discussion, consultation and referral to plan ongoing care.

6.1.2 Where conditions present with differing levels of complexity, more than one guidance level may be recommended (A/B, B/C, A/B/C).

6.1.3 Determining the guidance level will depend on the whole clinical picture including the complexity of the condition and clinical judgement of the midwife in consultation with the relevant medical practitioner/s or other healthcare providers as required.

6.1.4 Any indication may be re-evaluated and require escalation of care if additional support is needed at any time.

6.1.5 The roles and responsibilities of all involved in care provision will be discussed and agreed with the woman and healthcare providers.

6.1.6 Informed consent of the woman is required for any change to the care plan or lead care provider and communicated to all parties involved.

6.2 Discuss

6.2.1 The midwife may choose to discuss clinical situations with a midwife colleague, medical practitioner, and/or other healthcare providers.

6.2.2 The former Level A* (midwife with endorsement to prescribe scheduled medicines) has been consolidated into Level A in this edition. All midwives are to provide care according to their own scope of practice.

6.3 Consult

6.3.1 Where the woman provides informed consent for a consult, it is the midwife's responsibility to initiate a consult with a relevant medical practitioner or other healthcare provider as indicated.

6.3.2 The appointment/visit with a medical practitioner or other healthcare provider may occur:

- with the woman (or parent/s if related to the baby) specific to the indication. The midwife may or may not attend the consult.

OR

- between the midwife and the medical practitioner or other healthcare provider where the woman/baby is unable to or chooses not to attend. In this situation, the consultation may be undertaken by the midwife, on behalf of the woman.

6.3.3 May be conducted in person; via telehealth; telephone; virtually OR a combination of these to facilitate the appointment.

6.4 Refer

6.4.1 Where the woman provides informed consent for a referral, it is the midwife's responsibility to refer the woman to a relevant medical practitioner or other healthcare provider/s.

6.4.2 The appointment/visit with a medical practitioner or other healthcare provider/s may occur as noted in 6.3.3.

6.4.3 The midwife will continue to provide midwifery care to the woman, working in partnership and collaboration with the medical practitioner and relevant healthcare provider/s.

6.4.4 If the lead care provider transfers from the midwife to a medical practitioner, the woman must provide informed consent prior to transfer of responsibility of care. This will include a discussion about appropriate timing, nature of the transfer, and will incorporate the ongoing involvement of the midwife in providing primary maternity care. It will also address the possibility and timing of care being transferred back to the midwife where the clinical condition/s permits.

6.5 Declining recommended care

6.5.1 If a woman chooses to decline recommended care, document the woman's concerns and decision as well as any advice and/or information provided in the clinical record. Appendix A may be used as a tool to plan care together.

6.5.2 Where midwives require decision-making support about continuation or cessation of care for ethical or legal reasons, it is important to seek professional and legal advice including but not limited to their insurer. (Refer to Section 10 and Appendix A)

6.6 Documentation

6.6.1 Midwives and all healthcare providers involved in care are responsible for clearly documenting all discussions and decisions for all levels of guidance (A/B/C) in the woman's maternity care record and/or via electronic means as determined by local policy or protocol.

6.6.2 Documentation is to include but is not limited to:

- The condition/indication/s requiring care provision
- Healthcare provider/s engaged for care provision
- Outcome of discussions
- Ongoing plan of care
- Lead care provider (in particular where clinical responsibility for care transfers from one healthcare provider to another).

7 ANTENATAL

(Clinical indications developed prior to or during the antenatal period)

7.1 Previous intrapartum history

7.1.1	**Caesarean section**	B/C
7.1.2	**Forceps or vacuum birth**	A/B
7.1.3	**Other significant obstetric event** May include but not limited to: • amniotic fluid embolism (AFE) • conversion to a general anaesthetic for caesarean section • maternal collapse • necrotising fasciitis • previous high epidural or spinal block causing respiratory distress • uterine rupture	B/C
7.1.4	**Perineal or other laceration**	
	Cervical laceration	B/C
	Episiotomy – with complications or ongoing concerns	B
	Perineal abscess	B
	Perineal tear dehiscence	B
	Third or fourth degree perineal laceration	B/C
	Vulval or perineal haematoma requiring surgical treatment	B
7.1.5	**Postpartum haemorrhage**	
	Minor 500-1000mL	B
	Major >1000mL	C
7.1.6	**Shoulder dystocia**	B

7.2 Previous neonatal history

7.2.1	**Congenital and/or hereditary disorder of a previous child**	B
7.2.2	**Haemolytic disease of the fetus and newborn (HDFN)**	B
7.2.3	**Infection**	
	Neonate with other infection requiring admission	B/C
	Previous Group B Streptococcus (GBS) positive neonate	B
7.2.4	**Neonatal asphyxia** • APGAR <7 at 5 mins	B
7.2.5	**Stillbirth or neonatal loss**	B/C

7.3 Health systems and disorders

7.3.1	**Alcohol and other drug use**[15, 16]	
	Alcohol and other drug dependence	B/C
	Alcohol and other drug use including recent or current tobacco smoking, e-cigarettes or vaping	A/B
7.3.2	**Anaesthetic considerations**	
	Body Mass Index (BMI) > 40[17]	B/C
	Difficult intubation	B
	Difficult or unsuccessful epidural or spinal	B
	Malignant hyperthermia	C
	Neuromuscular disease or family history	B
7.3.3	**Autoimmune conditions**	
	Autoimmune connective tissue disease	B/C
	Periarteritis nodosa	C
	Rheumatoid arthritis	B/C
	Scleroderma	C

	Sjögren's syndrome	C
	Systemic lupus erythematosus (SLE)[18, 19]	C
7.3.4	**Cardiac**	
	Arrhythmia/palpations; murmurs:[20, 21] • new onset in pregnancy • pre-existing with cardiac clearance in pregnancy • recurrent/persistent/symptomatic	 B B C
	Cardiac valve disease	C
	Cardiac valve replacement	C
	Cardiomyopathy	C
	Congenital cardiac disease	C
	Ischaemic heart disease	C
	New onset cardiac conditions or symptoms including but not limited to:[22-24] • dyspnoea (shortness of breath) including at rest • orthopnoea (shortness of breath in the recumbent position) • paroxysmal nocturnal dyspnoea • chest pain • syncope • persistent cough	B/C
	Pulmonary hypertension	C
	Rheumatic heart disease (RHD)	C
7.3.5	**Cancer**[25-29] • previous history • current pregnancy Note: see: 7.3.9; 7.3.13; 7.4.1, 7.4.2, 7.6.21 for symptoms requiring further investigation	 B C
7.3.6	**Connective tissue diseases or other systemic and rare disorders**	
	Marfan's syndrome	C
	Raynaud's disease	A/B
	Other genetic, systemic or rare disorders	B/C

7.3.7	**Dermatological disorders**	
	Dermatological disorders requiring systemic therapy	B
	Current change in an existing mole or the appearance of a new skin lesion	B
7.3.8	**Endocrine**	
	Addison's disease, Cushing's disease or other endocrine disease requiring treatment	C
	Gestational diabetes[30] – diet controlled • previous history • current pregnancy	 A B
	Gestational diabetes[30] – uncontrolled and/or requiring medication • previous history • current pregnancy	 B C
	Overt diabetes in pregnancy[30]	C
	Pre-existing Type I and Type II diabetes[30]	C
	Thyroid • sub-clinical hypothyroidism • hypothyroidism • hyperthyroidism	 A B B
7.3.9	**Gastro-intestinal and hepatobiliary**	
	Acute abdominal pain (suspected cause not related to pregnancy)	B
	Acute hepatitis or jaundice	B/C
	Appendicitis – current pregnancy	C
	Cholecystitis or biliary colic	B
	Cholelithiasis – current pregnancy	B
	Cholestasis	C
	Gastric banding/sleeve	B
	Gastric bypass surgery	C
	Inflammatory bowel disease (IBD) including ulcerative colitis and Crohn's disease	B/C

	Other acute presentation (gastrointestinal/hepatobiliary)	B
	Rectal bleeding or persistent change in bowel movements	B
	Unexplained weight loss prior to or during pregnancy	C
7.3.10	**Haematological**	
	Iron deficiency (ID)[31] • Ferritin (Fe) <30mcg/L, with or without mild anaemia – Haemoglobin (Hb) 100-109g/L	A/B
	Anaemia[31-32] • moderate iron-deficiency anaemia (Fe <30mcg/L and Hb 70-99g/L) • macrocytic anaemia (Hb 70-110g/L and mean cell volume (MCV)≥100 fL) • severe anaemia (Hb <70g/L +/- MCV ≥ 100 fL)	 B/C B/C C
	Haemolytic anaemia	C
	Megaloblastic anaemia	B
	Mean corpuscular volume <80	B
	Sickle cell conditions	C
	Thalassaemia	C
	Blood clotting disorders	
	Coagulation disorders	B/C
	Von Willebrand's disease	C
	Thrombocytopenia[33] • <150 X 109/L but >100 × 109/L • <100 × 109/L	 B C
	Thrombophilia including: • anti-phospholipid antibodies and hereditary thrombophilia other than methylenetetrahydrofolate reductase (MTHFR) mutation (heterozygous) • on anti-coagulation therapy	C
	Thrombophilia – MTHFR mutation (heterozygous)	B

	Venous thromboembolism (VTE)	
	Pulmonary embolism (PE)[34] or deep vein thrombosis (DVT) • previous history • current pregnancy	 B C
	Risk factors for VTE indicating thromboprophylaxis medication[35]	B/C
	Blood incompatibilities	
	ABO blood group antibodies	B
	Anti-platelet antibodies (neonatal alloimmune thrombocytopenia-NAIT)	C
	Auto-immune thrombocytopenia	C
	Anti red cell antibodies with known association with haemolytic disease of the fetus and newborn (HDFN) (e.g., Rh, Kell, Duffy, Kidd)	C
	Rhesus isoimmunisation or rhesus antibodies	C
	Women declining the use of blood products Note: see Appendix A	B
7.3.11	**Hypertension**[36]	
	Chronic hypertension (pre-existing or <20 weeks)	B/C
	Gestational hypertension • previous pregnancy • current pregnancy	 B B/C
	Preeclampsia (including eclampsia and haemolysis, elevated liver enzymes and low platelets (HELLP) variant) • previous pregnancy • current pregnancy	 B/C C
7.3.12	**Infectious disease** Note: see 7.3.16 for renal/kidney infections and 7.3.17 for respiratory infections	
	Chlamydia[37, 38]	A/B
	Cytomegalovirus (CMV) – primary or recurrent infection[37]	B/C

	Genital herpes[37, 38] • Herpes simplex virus (HSV) Type 1 or 2 – active lesions in late pregnancy • HSV 1 or 2 - primary infection • previous/recurrent infection	 B/C B/C A/B
	Gonorrhoea[37, 38]	B
	Group B Streptococcus – bacteriuria or colonisation[37]	A/B
	Hepatitis A/B/C/D/E[37-39]	B/C
	Human immunodeficiency virus (HIV) infection[37, 38] • newly diagnosed in pregnancy • high viral load • low viral load	 C C B
	Listeriosis[37]	B/C
	Parasitic infection	A/B
	Parvovirus[37]	B
	Rubella[37]	B/C
	Sepsis[40]	C
	Syphilis[37, 38]	B/C
	Toxoplasmosis[37]	B/C
	Trichomoniasis[38]	A/B
	Tuberculosis	B
	Varicella zoster virus[37]	B
	Zika[37]	B
7.3.13	**Neurological**	
	AV malformations	C
	Bell's palsy	A
	Carpal tunnel syndrome	A/B
	Cerebral venous thrombosis	C
	Epilepsy with medication or seizure in the past 12 months	C
	Epilepsy – past history or without medication and no seizures in the past 12 months	B
	Headaches (persistent and unrelieved by simple analgesia)	B
	Hernia nuclei pulposus/pulposi (Slipped disc)	B
	Migraines (including change in migraine features or worsening in pregnancy)	B
	Multiple sclerosis	B
	Muscular dystrophy or myotonic dystrophy	C
	Myasthenia gravis	C
	Neuropathies or palsies	B/C
	New onset of seizures	C
	Spinal cord lesion (paraplegia or quadriplegia)	C
	Stroke/Cerebrovascular accident (CVA)	C
	Subarachnoid haemorrhage, aneurysms	C
7.3.14	**Organ transplants**	C
7.3.15	**Psychological or mental health concerns[41] – past history, pre-existing, or diagnosed in current pregnancy**	
	Acute and/or escalating mental health concern	C
	Antenatal depression and/or anxiety	B
	Birth trauma	A/B/C
	Edinburgh Postnatal Depression Scale (EPDS) >12	B/C
	EPDS – positive response to self-harm question (Q10)	B/C
	Mental health condition requiring medication	B
	Other perinatal mental illness	A/B/C
	Pica	B
	Postnatal depression	A/B
	Post traumatic stress disorder (PTSD)	B
	Puerperal psychosis – previous history	B/C
	Tokophobia	A/B

7.3.16	**Renal**	
	Glomerulonephritis	C
	Haematuria	A/B
	Previous kidney surgery (potential to impair kidney function during pregnancy)	C
	Pyelonephritis	C
	Renal function disorder with or without dialysis	C
	Urinary tract infection (UTI)	A/B
7.3.17	**Respiratory**	
	Asthma – mild[42]	A
	Asthma – moderate[42]	B
	Asthma – severe[42]	C
	Infectious respiratory illness (moderate to severe symptoms) (e.g., Influenza A or B, H1N1, COVID-19, pneumonia)	B/C
	Non-infectious respiratory illness (e.g., interstitial lung disease, sarcoidosis, severe lung function disorders, cystic fibrosis)	C
7.3.18	**Skeletal**	
	Developmental skeletal disorders	B
	Osteogenesis imperfecta	C
	Pelvic fracture and/or surgery	B
	Scheuermann's disease	B/C
	Scoliosis • without rods • with rods	 B C
	Spinal injury and/or surgery	B
	Spondylolisthesis	B/C

7.4 Gynaecological considerations

7.4.1	**Breasts**	
	New onset breast symptoms persisting over 7 days[27, 43] • Breast lesion or lump • Breast erythema • Breast pain • Skin distortion on the breast • Abnormal nipple appearance or discharge (not related to pregnancy or lactation)	B
	Breast implants	A/B
	Breast surgery that may impact lactation	A/B
7.4.2	**Cervical anomalies, conditions or surgery**	
	Cervical cerclage	C
	Cervical laceration	B/C
	Cervical surgery (including cone biopsy, laser excision or large loop of the transformation zone (LLETZ) biopsy) • with subsequent vaginal term birth • without subsequent vaginal birth	 A B
	Cervix – surgical removal of	C
	Cervical screening and cytology abnormalities[44]	
	Cervical screening • abnormal cervical screening requiring follow up in pregnancy • no previous cervical screen >25 years of age or cervical screening overdue[45]	 B A
	Evidence of invasive disease	C
	Human papilloma virus (HPV) positive (not type 16/18) with liquid-based cytology (LBC) or possible or low-grade squamous intraepithelial lesion (pLSIL/LSIL)	A

	HPV positive (not type 16/18) with LBC, possible or confirmed high grade squamous intraepithelial lesion (pHSIL/HSIL) or any glandular abnormality in pregnancy	B
	HPV positive (type 16/18) in pregnancy	B
7.4.3	**Pelvic or vaginal anomalies, conditions or surgery**	
	Dyspareunia	B/C
	Female genital mutilation (FGM)/cutting	B/C
	Incontinence – faecal or urinary	B/C
	Other congenital reproductive tract anomaly[46] (e.g., longitudinal vaginal septum, transverse vaginal septum, complex anomalies)	C
	Pelvic deformities (trauma, symphysis rupture, rachitis)	B
	Pelvic or vaginal surgery (e.g., colpo-suspension, mid-urethral sling, pelvic floor reconstruction)	C
7.4.4	**Uterine anomalies, conditions or surgery**	
	Fibroids	B
	Intrauterine contraceptive device (IUD) in situ	B/C
	Myomectomy or hysterotomy	C
	Uterine didelphys, bicornuate uterus, unicornuate uterus, septate uterus[46]	C

7.5 Other considerations

7.5.1	**Consanguineous relationship**	B
7.5.2	**Identified dental health concerns**	A/B
7.5.3	**Gender reassignment procedures and/or hormonal therapy (e.g., Testosterone)**	B/C

7.6 Pregnancy

7.6.1	**Assisted reproductive technology (ART) or fertility treatment**	B
7.6.2	**Clinical discrepancies with symphysio-fundal height (SFH), fetal growth and/or amniotic fluid**	
	SFH discrepancy[47] • plotting below the 10th centile or • ≥3cm less than expected or • serial measurements demonstrating slow or static growth	A/B
	Fetal growth restriction (FGR)	
	FGR – previous history	B
	Risk factors for FGR or unsuitable for assessment by SFH	A/B
	FGR in current pregnancy[48-50] • Early FGR (< 32 weeks gestation) ◦ Ultrasound estimated fetal weight (EFW)/abdominal circumference (AC) <3rd centile for gestation OR umbilical artery absent end-diastolic flow (AEDF) OR ◦ AC/EFW < 10th centile combined with ◦ Uterine artery pulsatility index >95th centile and/or ◦ Umbilical artery pulsatility index >95th centile • Late onset FGR (≥32 weeks gestation) AC/EFW < 3rd centile OR at least two of the following: ◦ AC/EFW < 10th centile ◦ AC/EFW crossing centiles >2 quartiles on growth centiles ◦ Cerebroplacental ratio <5th centile or umbilical artery pulsatility index >95th centile	C
	Large for gestational age (LGA)	
	LGA – previous history	A/B
	LGA – ultrasound estimated fetal weight (EFW) and/or abdominal circumference (AC) ≥90th centile for gestation[50] with no other risk factors	A

	LGA – ultrasound EFW and/or AC ≥90th centile for gestation[50] with risk factors (e.g., diabetes, previous shoulder dystocia)	B
	Macrosomia	
	Macrosomia (>4500g) – previous history	B
	Suspected fetal macrosomia – ultrasound EFW and/or AC ≥ 95th centile for gestation[51]	B/C
	Small for gestational age (SGA)	
	SGA – previous history	A/B
	SGA – ultrasound EFW 3rd-10th centile[50] with normal fetal wellbeing (normal liquor & dopplers)	B
	SGA – ultrasound EFW 3rd-10th centile[50] with abnormal fetal dopplers and/or abnormal liquor measurements	C
	Liquor volume[52]	
	Oligohydramnios • amniotic fluid index (AFI) <5cm or deepest vertical pocket (DVP) ≤2cm	B/C
	Polyhydramnios (mild) • >25cm AFI or DVP >8cm	B
	Polyhydramnios (severe) • >34cm AFI or DVP >14cm	C
7.6.3	**Ectopic pregnancy**[53]	
	Tubal ectopic pregnancy	C
	Non-tubal ectopic pregnancy • interstitial ectopic pregnancy • cervical ectopic pregnancy • caesarean scar pregnancy	C
7.6.4	**Fetal**	
	Fetal anomaly	A/B/C
	Fetal movements[54] • change in pattern, frequency and/or strength	A/B
	Intrauterine fetal death (IUFD)[55]	C

7.6.5	**Grand multiparity ≥5**	B
7.6.6	**Hyperemesis gravidarum or nausea and vomiting in pregnancy (NVP) (moderate or severe)**[56]	B
7.6.7	**Malpresentation/non cephalic presentation at full term**	
	Breech presentation at ≥36 weeks	B
	Unstable lie	B/C
7.6.8	**Maternal age**	
	<16 years	B
	>40 years	B
7.6.9	**Multiple pregnancy**	C
7.6.10	**No antenatal care in pregnancy (at term)**	B
7.6.11	**Placental/cord indications**	
	Cord or placenta anomalies requiring further investigations/ monitoring (e.g., velamentous cord insertion)[57]	B
	Placenta – previous history • abruption • accreta, increta, percreta • manual removal	 B C B/C
	Placental abruption	C
	Placenta accreta, increta or percreta	C
	Placenta praevia	C
	Vasa praevia	C
7.6.12	**Post-term or post-dates pregnancy**	
	Post-term pregnancy (≥42 completed weeks)	B/C
	Post-dates pregnancy (41-42 completed weeks)	A/B
7.6.13	**Preterm labour and/or birth**	
	Cervical shortening <25mm	B
	Preterm birth • previous history	B/C

	Preterm cervical dilation	C
	Threatened preterm labour • previous pregnancy	B
	Threatened preterm labour • <34 weeks • >34 weeks	 C B/C
7.6.14	**Preterm prelabour rupture of membranes** • previous history • current pregnancy	 B B/C
7.6.15	**Recurrent miscarriage** • loss of two or more intrauterine pregnancies of up to 20 weeks' gestation[53]	B
7.6.16	**Screening tests - first or second trimester**[58] • abnormal or moderate-high risk/chance results	B
7.6.17	**Surgery during pregnancy** • major surgery • minor surgery	 C A/B
7.6.18	**Termination of pregnancy (ToP)**	
	>3 ToP	B
	ToP for genetic/congenital reasons • previous pregnancy • current pregnancy	 A/B C
7.6.19	**Trophoblastic disease (Gestational trophoblastic disease (GTD)**[59]	
	• previous history • current pregnancy	A/B B/C
7.6.20	**Uncertain duration of pregnancy by amenorrhoea >20weeks**	A/B
7.6.21	**Vaginal blood loss**	
	Recurring loss <12 weeks	A/B
	Recurring loss ≥12 weeks	B
	Antepartum haemorrhage	B/C

8 INTRAPARTUM

(Clinical indications during the intrapartum period)

8.1.1	**Amniotic fluid embolism (AFE)**	C
8.1.2	**Artificial rupture of membranes (ARM)**	
	Induction of labour/augmentation with fetal head engaged	A/B
	Controlled ARM (fetal head not engaged)	B
8.1.3	**Breech presentation**	
	Diagnosed prior to or during labour – vaginal birth	B/C
	Diagnosed during labour – caesarean section indicated	C
	Undiagnosed with good progress in labour, frank or complete breech	B/C
	Undiagnosed with delayed/stalled progress in labour, footling or kneeling breech	C
	Breech extraction	C
8.1.4	**Caesarean section**	C
8.1.5	**Cord prolapse or presentation**	C
8.1.6	**Fetal death during labour/stillbirth**[55]	C
8.1.7	**Fetal monitoring**[60]	
	Normal cardiotocography (CTG) – features associated with low probability of fetal compromise	A
	Abnormal CTG – features are unlikely to be associated with fetal compromise when occurring in isolation	B
	Abnormal CTG – features may be associated with fetal compromise and require further action	B/C
	Abnormal CTG – features are likely to be associated with fetal compromise and require immediate management	C
8.1.8	**Group B Streptococcus (GBS) positive**	A/B
8.1.9	**Genital herpes (active in late pregnancy or at labour onset)**[37]	C
8.1.10	**Haemoglobin <110g/L in labour**[61]	B

8.1.11	**Haemorrhage**	
	Intrapartum haemorrhage	
	• asymptomatic and/or <50mL	A/B
	• symptomatic and/or >50mL	C
	Postpartum haemorrhage	
	Estimated blood loss <1000mL and asymptomatic	A/B
	EBL >500ml and symptomatic	B
	EBL >1000ml	B/C
8.1.12	**Hypertension**[36]	
	Chronic	B/C
	Gestational	B/C
	Pre-eclampsia (including eclampsia and haemolysis, elevated liver enzymes and low platelets (HELLP) variant)	C
8.1.13	**Maternal collapse/shock**	C
8.1.14	**Maternal sepsis**	C
8.1.15	**Meconium stained liquor (MSL)**	B
8.1.16	**Multiple pregnancy**	C
8.1.17	**Non-vertex presentation other than breech** e.g., brow, face and shoulder	C
8.1.18	**Induction of labour**	B/C
8.1.19	**Instrumental birth**	C
8.1.20	**Maternal vital signs** Persistent deviation from normal including: • bradycardia • tachycardia • hypertension • hypotension • tachypnoea • pyrexia >38°C (2 consecutive readings at least an hour apart)	B/C

8.1.21	**Newborn**	
	APGAR <7 @ 5 minutes	C
	Cord avulsion	B/C
	Resuscitation – interventions required	B/C
	Suspected feto-maternal haemorrhage	C
8.1.22	**Oxytocin infusion**	
	Augmentation	B
	Induction of labour	B
	Other indications (e.g., PPH management)	B/C
8.1.23	**Placental abruption and/or praevia (suspected or confirmed)**	C
8.1.24	**Preterm labour**	
	<34 weeks	C
	<37 weeks but >34 weeks	B/C
8.1.25	**Prolonged labour**	
	Prolonged active first stage (>5cm dilated)[62] • no cervical change in 4 hours • nil descent of presenting part • incoordinate contractions • cessation or change in strength, duration and frequency of contractions • deep transverse arrest	B/C
	Prolonged second stage – Primipara • birth is not imminent after 2 hours	B/C
	Prolonged second stage – Multipara • birth is not imminent after 1 hour	B/C
8.1.26	**Regional anaesthetic**	
	Epidural	B/C
	Spinal	C

8.1.27	**Retained placenta**	B/C
8.1.28	**Rupture of membranes (ROM)**	
	ROM at term >24 hours in the absence of abnormal fetal heart rate, meconium stained liquor, signs of infection	B
	ROM associated with abnormal fetal heart rate, meconium stained liquor, signs of infection	B/C
	ROM with known Group B Streptococcus (GBS) positive or previous history of baby with early-onset GBS	B/C
8.1.29	**Shoulder dystocia**	B/C
8.1.30	**Third or fourth degree perineal tear**	C
8.1.31	**Unengaged head in active labour**	
	• primipara	B
	• multipara	A/B
8.1.32	**Uterine inversion**	C
8.1.33	**Uterine rupture**	C
8.1.34	**Vasa praevia**	C

9 POSTNATAL

(Clinical indications during the postnatal period)
1st hour post birth until 8 weeks post birth

9.1 Maternal

9.1.1	**Alcohol or other drug dependence**[15]	B/C
9.1.2	**Bowel/urinary function**	
	Faecal and/or flatal incontinence	C
	Urinary incontinence – persistent[63]	B
	Urinary retention[64]	A/B/C
9.1.3	**Hypertension**[36]	
	Hypertension – persistent	C
	Preeclampsia (including eclampsia and haemolysis, elevated liver enzymes and low platelets (HELLP) variant)	C
9.1.4	**Lactation complexities** Note: see 7.4.1 breast symptoms requiring further investigation and 9.1.5 for mastitis and breast abscess[61]	A/B
9.1.5	**Maternal infection – suspected or actual**	
	Breast abscess[65]	B/C
	Endometritis	A/B/C
	Mastitis[65]	A/B
	Pyelonephritis	B/C
	Pyrexia >38°C[40]	A/B
	Sepsis[40]	C
	Suspected retained products of conception	B/C
	Urinary tract infection (UTI)	A/B
	Wound infection – (e.g., caesarean incision, perineal)	A/B
9.1.6	**Post-dural headache**	C

9.1.7	**Prolapse** • uterine • cystocele • rectocele	C
9.1.8	**Postpartum haemorrhage (PPH)**	
	Primary PPH – dependent on symptoms and clinical condition[66]	A/B/C
	Secondary PPH – dependent on symptoms and clinical condition[66]	A/B/C
9.1.9	**Psychological and perinatal mental health**[41]	
	Birth trauma	A/B/C
	History of antenatal depression/anxiety during pregnancy	A/B/C
	Other serious psychological disturbance	C
	Postnatal depression and/or anxiety	B/C
	Puerperal psychosis	C
9.1.10	**Pulmonary embolism (PE)**	C
9.1.11	**Stroke/Cerebrovascular accident (CVA)**	C
9.1.12	**Thrombophlebitis or thromboembolism**	C

9.2 Newborn

A baby from birth to 8 weeks of age

9.2.1	**Congenital abnormalities**	C
9.2.2	**Failure to pass urine or meconium within 24 hours of birth**	B
9.2.3	**Findings on screening and/or assessment of the newborn requiring further investigation and/or treatment including but not limited to:** • abnormal vital signs (e.g., oxygen saturations, heart rate, respiratory rate, temperature) • abnormal findings on newborn examination • abnormal blood glucose level • birth weights <10th centile and >90th centile • birth injury/trauma • cyanosis or pallor	B/C
9.2.4	**Growth not within expected parameters** • head circumference • length • weight	A/B
9.2.5	**Feeding problems**	A/B
9.2.6	**Jaundice** • <24 hours or persistent >14 days • >24 hours but <14 days	 C A/B
9.2.7	**Neonatal abstinence syndrome (NAS)/substance withdrawal requiring treatment**	B/C
9.2.8	**Neonatal infection – suspected or actual**	B/C
9.2.9	**Preterm birth <37 weeks**	B/C
9.2.10	**Seizure activity observed or suspected**	C
9.2.11	**Single umbilical artery**	A/B/C
9.2.12	**Vomiting** • excessive • green, bile stained (Bilious) • projectile	 A/B C B

10 WHEN A WOMAN CHOOSES TO DECLINE RECOMMENDED CARE

A woman has the right to make autonomous decisions regarding care following consideration of their needs and beliefs, and/or their baby's needs as well as the benefits, risks and alternatives of any aspect of care. This document is a tool for midwives and healthcare providers to use when a woman declines recommended care.

Background

The principles that underpin healthcare and health law both emphasise the importance of respecting the autonomy and rights of individuals to weigh benefits, risks and alternatives according to their personal needs and values and make independent and informed decisions.

A woman in the care of a midwife may, at times, choose to decline recommended care. It is also possible that a woman receiving midwifery care may either choose care that the midwife has determined is beyond their ability to safely manage within their scope of practice or decline care that the midwife considers essential for the provision of safe care.

Midwives are responsible for:

- providing holistic, woman-centred care
- clearly describing their scope of practice
- providing care that is consistent with the national professional standards for midwives
- providing advice and care that is consistent with the Guidelines
- providing information about the benefits and risks of any aspect of care including alternative approaches and possible outcomes from declining recommended care
- providing information and advice that is consistent and sourced from evidence-based sources that are easily understood by the woman

Declining recommended care

When a woman chooses to decline recommended care, the midwife will discuss the benefits, risks and alternatives of this decision with the woman (and with relevant staff/colleagues through identified channels where appropriate). As part of that discussion, it is important to understand the woman's reasoning and the basis for decision making, and confirm the woman understands this decision lies outside the recommendations for care. It is also important to explore available options and possible resolutions, within midwifery professional standards, to address the woman's needs and rights to make an informed decision.

In summary:

1. **Advise** the woman about the recommendation for care and the reasoning and evidence including benefits, risks and alternatives.
2. **Support** the woman to access relevant, culturally informed, evidence-based information and facilitate the opportunity for questions and clarification.
3. **Consult** with another midwife and/or a medical practitioner, with the woman's consent and document outcomes.
4. **Offer** the woman the option to access a second opinion from other healthcare providers.
5. **Discuss** the professional advice provided during the consultation with the woman and invite them to share any guidance received along with their reflections and understanding of the information shared.
6. **Document** the advice, process and outcomes of the decision, and record relevant details. The ACM recommends using the 'Record of Understanding' provided in Appendix A.
7. **Provide** a reasonable amount of time for the woman to consider the information and options discussed. Document the woman's informed decision and awareness that the decision can be reviewed and/or changed at any time.

If, after completing steps 1 to 7 above, a satisfactory resolution has still not been reached (for either the woman or the midwife), the midwife may decide whether to continue care (including care that is subject to any mutually agreed conditions and/or restrictions) or to discontinue care and offer to find the woman another registered maternity care provider.

Continuing or discontinuing care

The decision to continue or discontinue care when a woman chooses to decline recommended care is complex and requires considered professional and ethical decision-making.

The midwife's decision must be informed by their:

- professional standards
- ethical judgment
- scope of practice
- ability to justify their decision-making to a reasonable body of peers.

In making the decision, the midwife needs to consider the:

- woman, baby and nominated partner/s
- midwife's own well-being, and other healthcare providers that may be engaged in care of the woman.

The midwife's responsibility is to offer evidence-based guidance and facilitate informed decision-making. Clearly communicate that, if the woman continues care with the midwife, the midwife's ongoing provision of care does not imply agreement with the woman's decision, however respects the woman's right to self-determination.

Similarly, the midwife must ensure the decision to discontinue care is not used coercively, but that it adequately conveys the gravity of the midwife's concern.

The midwife can consult with other registered maternity care provider/s if needed and seek support from their professional body and insurer.

If care continues

If the midwife decides to continue care:

- continue to inform the woman about changes in the health and wellbeing of themselves and/or their baby.
- continue to make recommendations for safe care consistent with the Guidelines and any relevant broader evidence base.
- engage other registered maternity care providers who have or who may become involved in providing advice or care with the woman's consent.
- plan for the management of an emergency, including those that may be outside the midwife's scope of practice.
- document all discussions and decisions.

If care is discontinued

Discontinuation of care should not occur when a woman is in established labour or in an urgent or emergency situation. If the woman chooses to decline recommended care during active labour or in urgent or emergency circumstances, the midwife is obliged to attend to the woman they are caring for.

If the midwife decides to discontinue care:

1. Communicate the inability to continue to provide care to the woman, and the reasons why midwifery care is being discontinued. Document the discussion in the woman's maternity care record as determined by local policy or protocol.
2. Provide documented advice to the woman confirming the reasons why midwifery care is being discontinued. A specific date should be given for the cessation of care. The date should give the woman a reasonable length

of time to find another registered maternity care provider. A reasonable length of time will vary according to location and circumstance. If the woman is unable to arrange alternative care, make a reasonable attempt to find a registered maternity care provider who is willing to provide care to the woman.

3. Send a referral (see Appendix B) to the registered maternity care provider identified in (2) above, confirming the date on which the midwife will discontinue care of the woman. In the event that no registered maternity care provider has been identified, seek the woman's consent to send a referral to the nearest appropriate public maternity service.
4. Retain a copy of the correspondence stipulated in (2) and (3). Document in the woman's maternity care record, the attempt/s the midwife has made to find an alternative registered maternity care provider.
5. Provide the woman with a copy of their maternity care record and the referral letter. In relation to any advice or referrals which are sent, maintain receipt of sent and received correspondence.
6. Notify insurer as soon as is reasonably possible (if applicable).

During labour or when an urgent or emergency situation arises

If the woman chooses to decline recommended care during active labour or in urgent or emergency circumstances, the midwife is obliged to attend to the woman they are caring for. Where a woman has declined emergency transport or transfer of care during active labour, remain in attendance as the primary care provider. The midwife may be called upon to deal with an urgent situation, or one that is not within the midwife's standards, scope or ability to perform.

In the case of urgent or emergency circumstances:

1. If outside of the hospital setting:
    a. call an ambulance immediately to facilitate the most timely transfer of care (regardless if the decision to transfer is accepted or not).
    b. notify the hospital where the woman would be received if transfer occurred.
    c. call the second midwife to attend if not in attendance. The second midwife is to maintain their own contemporaneous notes documenting the care being provided, discussions and decisions.
    d. assess the need for additional resources and personnel.
2. If in a hospital setting, follow the hospital's escalation process.
3. Continue to inform the woman about changes in the health and wellbeing of themselves and/or their baby.
4. Continue to provide care within midwifery standards of practice.
5. Notify insurer as soon as is reasonably possible (if applicable).

Continue to document all care, discussions and decisions provided.

APPENDIX A: RECORD OF UNDERSTANDING

It is recommended that this form is completed when a woman chooses to decline recommended care or against the advice of the primary midwife. The form is most suitable when there is moderate to very high clinical risk, and when care is declined for the first time in a non-emergent situation and/or prior to active labour. It may not be suitable for low clinical risk, and when care is declined for the first time in an emergent situation and/or during active labour.
There are three parts in the record of understanding:

Part 1: Record of advice/discussions 1.1 1.2	☐ Completed by the midwife ☐ Completed by the woman
Part 2: Management plan	☐ Completed and signed by all relevant parties
Part 3: Declaration 3.1 OR 3.2	☐ Completed and signed by the woman and midwife OR ☐ Completed by the midwife

PART 1: Record of advice/discussions

PART 1.1: To be completed by primary midwife				
Date: ___ / ___ / _____	**Time:**			
What is your recommendation for care?				
What information or evidence have you provided to the woman to support decision making?	Describe context Supporting evidence Benefits Risks			
What alternative options were discussed? If no alternative options were discussed, document 'nil discussed' Repeat this section if multiple options discussed.	Option/s Supporting evidence Benefits Risks			
Has the woman provided consent for a consultation and/or referral with a medical practitioner and/or any other healthcare provider?	☐ Yes ☐ No If yes, who has the woman consulted with or been referred to? Date: Practitioner name: Practitioner role:			
With whom have you consulted with about the woman's care?	Date / time	Practitioner name	Practitioner role	Method
Summary of discussions				
Outcome of discussions with the woman	Woman's informed decision is: Next steps:			
Midwife details	Midwife name: Midwife signature: Ahpra registration number:			

PART 1.2: To be completed by the woman	
Date: ____ / ____ / _____	**Time:**
Do you need an interpreter or communication aid/s? ☐ No ☐ Yes	
Have the details above been accurately described and clearly explained in a way you understand?	☐ Yes ☐ No Comments:
Do you understand the recommendations and reasons why these have been recommended?	☐ Yes ☐ No Comments:
Did you have an opportunity to ask questions or have any concepts re-explained to you?	☐ Yes ☐ No Comments:
Are you satisfied that your questions have been clearly answered?	☐ Yes ☐ No Comments:
Do you feel you have received adequate, clear and relevant information to make an informed decision?	☐ Yes ☐ No Comments:
Have you made your decision freely, without pressure or undue influence?	☐ Yes ☐ No Comments:
Do you understand the potential benefits and risks to the health and wellbeing of yourself and/or your baby in making this decision?	☐ Yes ☐ No Comments:
I have made an informed decision to:	☐ Accept an alternative care option - Part 2: Management plan ☐ Decline recommended care ☐ Decline to complete this form
Please include any additional information that is important to you:	
Woman's details	Name: Signature:

The maternity clinical records of the woman are to reflect all decisions relating to this discussion and plan and any revisions to the woman's decision as care unfolds.

PART 2: Management Plan

This plan is to be completed where agreement on an alternate care plan has been reached.

Date: ____ / ____ / _____ Time:

In this section, outline the agreement you have reached with the woman about the ongoing care.
Specify each healthcare provider's role.

Date	Name	Signature	Role
____ / ____ / _____			☐ Woman
____ / ____ / _____			☐ Midwife
____ / ____ / _____			☐ Medical practitioner
____ / ____ / _____			☐ Other practitioner [state type]

This management plan is to be reviewed whenever there is a change of circumstances. The maternity care record is to reflect all decisions relating to this plan.

PART 3: Declaration

This declaration is to be completed if no agreement has been reached on an alternative care plan (Complete EITHER 3.1 or 3.2).

3.1: DECLARATION FOR THE CONTINUATION OF CARE WHERE THE MIDWIFE HAS ELECTED TO CONTINUE CARE OR CONTINUE CARE SUBJECT TO CERTAIN CONDITIONS.

This declaration is to be completed by the woman and the midwife.

As primary midwife, I have decided to continue to provide midwifery care.

☐ Reasons for decision to continue midwifery care
☐ Conditions/restrictions required for continued care
☐ Conditions upon which midwife may revisit the decision to continue care
Declaration by the woman: I, _____, have read and understood the contents of Parts 1.1, 1.2, 2 and 3.1 in this record of understanding. I have had the opportunity to ask questions and discuss possible alternatives. I am satisfied that my questions have been answered. I acknowledge that my midwife has concerns that we have not been able to resolve, and I agree to continued care by the midwife on the terms stipulated above. I understand that I am free to change my mind at any time and I will notify my midwife in that event at the earliest opportunity.
Signed: _____(Woman) Dated: ____ / ____ / _____ Time: _____
Signed: _____(Midwife) Dated: ____ / ____ / _____ Time: _____

3.2: DECLARATION FOR DISCONTINUATION OF CARE WHERE THE MIDWIFE HAS ELECTED TO DISCONTINUE CARE.

This declaration is to be completed by the midwife where agreement on an alternative care plan has not been reached.

NOTE: In the course of active labour or in urgent/emergency situations, the midwife is obliged to attend the woman.

As primary midwife, I have decided to discontinue providing midwifery care.

☐ Reasons for decision to discontinue providing midwifery care:	
☐ I have completed the following steps:	
Date	**Action**
____ / ____ / _____	Discussion with the woman informing discontinuation of care.
____ / ____ / _____	Correspondence sent to the woman confirming discontinuation of care (attach copy and proof of receipt).
____ / ____ / _____	Agreed date for the woman to have alternative care arrangements in place.
____ / ____ / _____	Sought consent from the woman to provide a referral to another registered maternity care practitioner and/or the nearest public maternity service (if applicable).
____ / ____ / _____	Referral sent to public maternity service (if applicable).
____ / ____ / _____	Letter sent to woman's usual treating General Practitioner (GP) advising of discontinuation of care.
____ / ____ / _____	Woman provided with a copy of maternity care record and referral.
I have made the following reasonable efforts to find a registered maternity care provider who is willing to provide care to the woman (if not applicable, insert N/A):	
Signed: _____(Midwife) Dated: ____ / ____ / _____ Time: _____	

APPENDIX B: SAMPLE LETTER TO REQUEST A CONSULTATION OR REFERRAL

It is strongly recommended that midwives provide an entry either in the clinical record or separately by letter when requesting a consultation or referral. It is expected that healthcare providers will communicate with the midwife in writing about their findings including any alteration in the plan of care. This is an accepted convention of communication across health care.

Sample letter

Midwife name:
Business details: (Add business name, address, email, phone, fax and Medicare provider number – if in private practice)

Specialist/Clinic/Hospital name: (Including address, email, phone, fax):

Date:
Dear Consultant/GP name,

Re:	Client's name:	DOB: __ /__ /__
	Address:	ID#:
	Phone number:	Medicare number:

Reason for referral: (Eg: Booking in / Request consultation for obstetric review / Request referral of care for 'XYZ' / 36 week update / 8 week discharge letter)

Thank you for seeing "Name" who is now ## weeks pregnant, EDD __ /__ /__ (G? P?). I am providing midwifery care for "name" who is planning to birth at "X hospital" OR "at home with X hospital as back up in case a transfer is needed". I have completed the Pregnancy Health Record at the booking in visit and according to the ACM National Midwifery Guidelines for Consultation & Referral 5th edition, "name" pregnancy is:

- Category B/C – Please arrange an obstetrician appointment at your earliest convenience
  [List corresponding categories that apply] For example:
  - 7.3.11 Chronic hypertension (B/C) – currently on Labetalol 100mg tds and has been commenced on Aspirin 150mg nocte
  - 7.4.2 Cervical surgery (Previous LLETZ procedure) with subsequent term vaginal birth (A) – cervical length 38mm noted at Morphology scan

[Provide additional details if needed to facilitate clear communication about reason to request a consultation and/or referral and if the midwife will be providing ongoing midwifery care.]

Please find attached:
1. Copy of Pregnancy Health Record
2. Dating, Nuchal and Morphology scan
3. 1st trimester pathology
4. Edinburgh Depression Scale and Psychosocial Assessment
5. Other information as required

Kind regards

Midwife's name and signature, Ahpra registration number

APPENDIX C: ACKNOWLEDGEMENTS

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