



**INFORMED CONSENT FOR OBSTETRICAL PROCEDURES
(Vaginal Birth after Cesarean Section)**

It is very important to Women's Health Center of Lebanon that you understand and consent to the treatment your doctor is rendering and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended. Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

Patient's Initials or Authorized Representative

Date

Vaginal Birth After Cesarean Section

1. I have had only one prior Cesarean section with a horizontal uterine incision.
2. I understand that if I choose a VBAC and end up having a Cesarean delivery during labor, I have a greater risk of problems than if I had an elective repeat Cesarean section.
3. I understand that I have the option of undergoing an elective repeat Cesarean section or attempting a vaginal birth after a Cesarean (VBAC).
4. I understand that a successful VBAC carries a lower risk to me than does a Cesarean section.
5. I understand that the risk of uterine rupture, the most serious complication, with a low transverse incision scar on the uterus, is around 1%. The fetal mortality rate in the event of a uterine rupture is 5.5%. A uterine rupture is an emergency in which the death or permanent brain injury of the baby may not be able to be prevented.
6. I understand that if I deliver vaginally, I most likely will have fewer problems after the delivery and have a shorter hospital stay than if I have a Cesarean delivery.
7. I understand that a Cesarean delivery has a higher risk of bleeding, infection than a successful VBAC. A Cesarean delivery has a maternal mortality rate of approximately 20 per 100,000 births.
8. I understand that a VBAC trial is associated with a higher risk of harm to my baby.

9. I understand that an elective repeat Cesarean section is the safest method of delivery for the baby.
10. I understand that the use of Pitocin has been shown to increase the risk of uterine rupture to around 2%. The risks of Pitocin have been explained to me as well.
11. I understand that in the event of a uterine rupture, emergency surgery will be performed, but my physician may not have enough time to prevent permanent injury to and/or the death of my baby and/or myself.
12. Neither a repeat Cesarean delivery nor a VBAC is free of risk.
13. I have read or have had read to me the above information and I understand it. Further, I understand that the decision to have VBAC is entirely my own and the alternative of an elective repeat Cesarean section has been discussed with me.

I also understand that unforeseen conditions may arise or be revealed during the procedure that may necessitate change or extension of the procedure that was explained to me. I therefore authorize and request that my physician, his/her assistants and/or appropriate designees perform such procedure as may be necessary or desirable in his/her professional judgment, for my safety and the safety of my baby.

I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being and safety.

I understand that there is no guarantee regarding the outcome of the procedure(s).

Other risks include obstetrical hemorrhage. At the time of delivery, after your baby has been born by vaginal birth or cesarean section, it is possible to develop severe bleeding, known as obstetrical hemorrhage. This may not, and often is not, able to be predicted before it occurs. This may occur because of placental abruption (premature separation of the placenta), uterine atony ("floppy" uterus), infection, retained pregnancy tissue, uterine rupture, or unknown causes. This emergency may require medications and massage of the uterus or may require emergency surgery which could include a hysterectomy (removal of the uterus) in order to control bleeding. Your doctor will use his or her clinical judgment in order to safeguard your health and will be available to you and your family to address concerns and questions.

I understand that emergencies or unforeseen medical conditions may arise at the time of my labor or delivery that may necessitate the performance of this procedure, or a change or extension of the procedure(s) explained to me. I, therefore, authorize and request that my physician, his/her assistants and/or appropriate designees perform such procedures as may be necessary in his/her professional judgment for my safety and the safety of my baby. I also understand that unforeseen conditions may arise or be revealed during the procedure that may necessitate change or extension of the procedure that was explained to me. I therefore authorize and request that my physician, his/her assistants and/or appropriate designees perform such procedure as may be necessary or desirable in his/her professional judgment, for my safety and the safety of my baby.

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

I consent to any photographing or videotaping of the procedure(s) that may be performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them, so that my physician may follow my therapy progression. I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

_____/_____/_____
Date Time Signature of Patient or Authorized Rep. Relationship of Authorized Rep

The Patient/Authorized Representative has read this form or had it read to him/her.

The Patient/Authorized Representative states that he/she understands this information.

The Patient/Authorized Representative has no further questions.

The Patient/Authorized Representative has read the form in Spanish.

I certify that I have asked the patient/authorized representative the above questions and her responses were noted above.

Date Time Signature of Witness

CERTIFICATION OF PROVIDER:

I hereby certify that I have discussed with the individual granting consent, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the procedure(s).

Date Time Signature of Provider

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

_____ Foreign language (specify)

_____ Sign language

_____ Patient is blind, form read to patient

_____ Other (specify) _____

Interpretation provided by _____

(Fill in name of Interpreter and Title or Relationship to Patient)

Signature (Individual Providing Assistance)

Date

Time