



TOLAC Referral Form

FAX TO UNC OB CLINIC AT 984-974-9023

Patient Name: _____

Referring provider: _____

Date of birth: _____

Referring clinic: _____

UNC MRN: _____

Referring clinic fax: _____

Please complete this form for any patient with a history of a c-section who is considering a Trial of Labor After C-Section (TOLAC) at UNC Women’s Hospital. The purpose of this form is to ensure that patients receive consistent counseling regarding mode of delivery following c-section and to identify patients at higher risk of complications who would benefit from being seen at UNC for a high risk consultation. To minimize patient travel burden, we encourage you to **complete this referral in early pregnancy (eg by 17 weeks EGA)** so that patients needing consultation can be seen at the time of their anatomy ultrasound.

Dating Criteria

LMP: _____

EDC: _____

"Best" EDC

U/S: _____ weeks

LMP
EDC: _____
US

Please confirm the following:

- Possibility of TOLAC has been discussed with patient and patient articulates desire for trial of labor or is uncertain regarding trial of labor vs. Elective Repeat C-section
- Patient is able to verbalize the advantages and risks of TOLAC
- Patient is aware that cesarean birth is a possibility with all labors and particularly with labors after previous cesarean birth

Documents attached

- Prenatal record, including all labs and ultrasound reports not documented in the UNC EMR

Operative report

- Copy of operative report for previous cesarean section attached
- Patient’s prior c-section was performed at UNC
- Operative report is not available

VBAC Calculator Data

Maternal age: _____ years

Height: _____ inches

Pre-pregnancy weight: _____ lbs

Race/ethnicity

- African-American
- Hispanic
- Other

Any previous vaginal delivery?

- Yes
- No

Any vaginal delivery since last cesarean?

- Yes
- No

Indication for prior cesarean of arrest of dilation or descent?

- Yes
- No

Predicted chance of successful VBAC: _____

Use calculator at <http://bit.ly/V8LkZI>

Is this a higher risk patient?	<input type="checkbox"/> Lower Risk	<input type="checkbox"/> Higher Risk
Is predicted VBAC success higher than 40%?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What type of incision was used for the prior c-section?	<input type="checkbox"/> Low transverse	<input type="checkbox"/> Low vertical <input type="checkbox"/> Unknown
Is the operative report for the prior c-section available?	<input type="checkbox"/> Yes, <i>it is attached to this form</i>	<input type="checkbox"/> No, it is not available
Has the patient had more than 1 prior c-section?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Any Higher-Risk indicators checked?	<input type="checkbox"/> No	<input type="checkbox"/> Yes -> refer to UNC for OB consult

Referring provider signature: _____ Date: _____

Request to UNC providers

Patient with prior c-section desires TOLAC and meets criteria for Lower Risk. **Please review and return this form for TOLAC approval.**

Trial of labor consent has been reviewed and signed by patient and referring provider
<http://www.mombaby.org/resources/request-consent-tolac/>

OR

Patient with prior c-section desires TOLAC and meets criteria for Higher Risk

Patient with prior c-section is uncertain regarding TOLAC vs. Elective Repeat C-Section and wishes to meet with a UNC provider to discuss mode of delivery

Patient is Lower risk, but remains undelivered at >40 weeks. Please schedule OB consultation for discussion of late term management.

UNC Provider Review

Patient meets criteria for lower risk TOLAC. This patient **IS** approved for a trial of labor.

Patient desires TOLAC and is higher risk. **Consultation at UNC is required** prior to TOLAC.

UNC Provider signature: _____ Date: _____

Scheduling:

Please schedule for OB consultation OR **Consultation has been scheduled**
Call 984-974-2131 to schedule

Please fax this form with the prenatal record, dating ultrasound and operative report to the UNC Hospital Obstetrics Clinic at 984-974-9023.

OB Consult Appointment Date: _____ Time: _____

Completed form faxed back to referring clinic on date: _____