

**REQUEST AND CONSENT FOR A TRIAL OF
LABOR AFTER A PREVIOUS CESAREAN DELIVERY
MIM # 303s - Revised 01/29/2014**

Name of patient _____ Age _____

1. I hereby request and authorize _____ and/or associates and assistants of his/her choice at the University of North Carolina Hospitals to permit me to have a trial of labor for my current pregnancy so that I can attempt to have a vaginal delivery. If available, my care providers have reviewed my medical records and determined that I had a low transverse (horizontal) incision on my uterus (womb) during my previous cesarean (surgical) birth. If my medical records could not be reviewed, my care providers have talked to me about the reason for my previous cesarean and, based on information I provided, believe that in all likelihood a low transverse incision was made in my uterus.

My care providers have explained to me that I would **NOT** be a candidate for a trial of labor in my current pregnancy if one or more of the following apply to me:

- a previous up and down (vertical) or T-shaped incision in my uterus
- a previous incision on the top of my uterus
- a medical problem or a problem related to pregnancy that would make a vaginal delivery unsafe for me or my baby
- having had three or more previous cesarean births.

I acknowledge that NONE of the four above-described circumstances apply to me.

If the operation or procedure is performed under the supervision of an attending physician or midwife, I understand that residents and/or assistants at the University of North Carolina Hospitals may perform selected tasks, which may include: opening and closing a surgical site; dissecting tissue; removing tissue, blood or body fluids; injecting medication(s); administering anesthesia; and placing invasive lines. At the time of the procedure, the attending physician or midwife will determine the extent of participation by the resident(s) and/or assistant(s) depending on: (1) the complexity of the procedure; (2) the unique circumstances of the patient; and (3) the training and experience of the resident(s) and/or assistant(s).

I understand a serious risk of labor after a previous cesarean birth is that the scar on the uterus may separate during labor. This is known as uterine rupture and occurs in approximately 1 in 100 women with a low transverse incision on the uterus. With other types of incision on my uterus, the risk of separation of the scar may be as high as 9 in 100 women who try to have a vaginal birth. If we don't know, we must assume the higher risk. In women who have had two previous cesarean births, the risk of uterine rupture is approximately 1-2 in 100 women. Because of this risk, my labor will be observed in the hospital and special monitoring may be used during labor to help evaluate my contractions and my baby's well being. If uterine rupture occurs, an emergency cesarean birth will be necessary. I understand that uterine rupture can have negative effects for my baby or me. I may require blood transfusions because of blood loss; in rare cases, the removal of my uterus (hysterectomy) may be necessary to stop the bleeding. Approximately one or two in 1000 women who attempt a trial of labor after a previous cesarean birth may deliver an infant with serious problems as a result of uterine rupture. These problems include brain damage or death of the baby.

I understand that the benefits of a vaginal birth are that I will not have a surgical operation and therefore I am less likely to have medical complications after giving birth. In addition, if I am able to have a vaginal birth, my hospital stay will usually be shorter than if I have surgery. Labor and being born through the vagina also help the baby take its first breaths. Having a vaginal birth may also decrease problems for me and my babies in future pregnancies.

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2. I hereby request that necessary and appropriate anesthesia and medications be given to me (the patient).
3. I have discussed with my health care provider the possibility of administering blood or blood products in connection with my operation or procedure.
- ☐ I authorize and request medically necessary blood and blood products be given to me (the patient) before, during or after the operation or procedure, as long as my medical condition and proposed treatment and associated risks have not changed.
 - ☐ I do NOT authorize blood or blood products be given to me (the patient). (The patient MUST also complete UNC Hospitals form HD 6113 "Refusal to Consent to the Use of Blood or Blood Products.")
4. I understand that, during labor or delivery, it is possible for something unexpected to happen which may require that another or different operation or procedure be performed on me (the patient). If something unexpected happens during labor or delivery, I hereby request and authorize my (the patient's) physician or midwife to do what is medically necessary and appropriate for me (the patient), including performing another or different operation or procedure.
5. I have had an opportunity to ask questions, have had those questions answered, and have received sufficient information so that I have a general understanding of:
- a. my (the patient's) **medical condition**,
 - b. the **nature** of the trial of labor after a previous cesarean birth,
 - c. the **benefits** of the trial of labor after a previous cesarean birth,
 - d. the usual and more frequent **risks** of a trial of labor after a previous cesarean birth,
 - e. the risks and benefits of the **alternative treatment(s)**, and a repeat cesarean birth
 - f. the likelihood of success for a vaginal delivery with a trial of labor.
6. Based on my discussion with my (the patient's) physician or midwife and the information that I have received, I give my consent to a trial of labor to attempt a vaginal birth.
7. I understand that the practice of medicine is not an exact science and no guarantees have been made concerning the results of labor or delivery.
8. For the purpose of advancing medical education, I give permission for observers to be present during my labor or delivery.
9. As long as my (the patient's) identity is not revealed, I give permission for employees of UNC Hospitals and/or the UNC School of Medicine to:
- a. take photographs or make drawings of me (the patient) for diagnostic, scientific, educational, or research purposes, and
 - b. examine and dispose of any tissue, blood, or body parts, which may be removed during the operation or procedure, and to use such tissue, blood, or body parts for teaching, educational, or research purposes.
10. I confirm that I have read this form, or that it was read to me, that all blank spaces were filled in, and all sections that I do not agree with were crossed out before I signed below.

Signature of patient (or person authorized to sign for patient)

Date

Time

Relationship to patient _____

**REQUEST AND CONSENT FOR A TRIAL OF
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PHYSICIAN/MIDWIFE CERTIFICATION

I hereby certify that the nature, purpose, benefits, usual and most frequent risks of, and alternatives to, the operation or procedure have been explained to the patient (or person authorized to sign for the patient) either by a physician or midwife or the provider who is to perform the operation or procedure; that the patient has had an opportunity to ask questions, and that those questions have been answered. The patient (or the patient's authorized representative) has been advised that selected tasks may be performed by assistants to the primary health care provider(s). I believe that the patient (or authorized representative) understands what has been explained, and has consented to the trial of labor after a previous cesarean birth.

Signature of physician/midwife

Date

Time

WITNESS CERTIFICATION

I hereby certify that the patient (or person authorized to sign for the patient) has EITHER (Check one box):

- ☐ 1. Acknowledged in my presence that he/she has received an explanation of the nature, purpose, benefits, usual and most frequent risks of a trial of labor and attempted vaginal birth and an explanation of the alternative of a repeat, planned cesarean birth and its risks and benefits, has had all of his/her questions answered, has given his/her consent, and has signed the form above; OR
- ☐ 2. Answered "yes" to all of the following questions:
- a. Did a health care provider explain the operation or procedure to you?
 - b. Did a health care provider explain that selected tasks may be performed by assistant(s)/resident(s)?
 - c. Did a health care provider explain alternative procedures and treatments and their risks and benefits?
 - d. Have all of your questions about the operation or procedure been answered?
 - e. Is this your signature on the consent form?
 - f. Have you given your consent for the operation or procedure?

Signature of witness

Date

Time