

**ARKANSAS DEPARTMENT OF HEALTH
HOSPITAL REPORTING FORM – LAY MIDWIFE PATIENT TRANSFER**

Act 977 of the 2019 Regular Session of the Arkansas Legislature requires that “A hospital or licensed healthcare facility shall report to the Department of Health when a known transfer occurs of a patient from the care of a lay midwife during the labor and delivery process to the hospital or licensed healthcare facility.” Transfer reports regarding a lay midwife patient during the labor and delivery process may be filed electronically through the Lay Midwife Patient Transfer Reporting Form below or via call, mail, fax or email directed to:

Women’s Health Section
Arkansas Department of Health
4815 W. Markham, Slot 16
Little Rock, AR 72205

Phone: (501) 661-2480
Fax: (501) 661-2464
Email: adh.whgen@arkansas.gov

*required information TYPE OR PRINT LEGIBLY IN INK

REPORTING HOSPITAL OR HEALTHCARE FACILITY INFORMATION			
Name of Facility*	Telephone Number*	Date of Patient Transfer*	
Street Address*	City*	State*	Zip Code*
CONTACT PERSON AT REPORTING HOSPITAL OR HEALTHCARE FACILITY			
Name*	Title*	Phone Number*	
Email Address			
INFORMATION ABOUT THE PATIENT			
Patient’s Last Name*	Patient’s First Name*	Patient’s Date of Birth*	
Street Address	City	State	Zip Code
REASON FOR TRANSFER* (Check all that apply)			
<u>INTRAPARTUM</u>	<u>POSTPARTUM</u>	<u>NEWBORN</u>	
<input type="checkbox"/> Prolonged or Arrested Labor <input type="checkbox"/> Fetal Position other than Vertex <input type="checkbox"/> Active Genital Herpes Lesions <input type="checkbox"/> Labor prior to 37 weeks 0 days <input type="checkbox"/> Bleeding in Labor <input type="checkbox"/> Meconium <input type="checkbox"/> Prolapsed Cord <input type="checkbox"/> Non-reassuring Fetal Heart Rate <input type="checkbox"/> Maternal Infection <input type="checkbox"/> Suspected or Confirmed Fetal Death <input type="checkbox"/> Maternal Elevated Blood Pressure <input type="checkbox"/> Unknown GBS Status <input type="checkbox"/> Other (Please describe): <hr/> Outcome of Delivery: <input type="checkbox"/> Vaginal Birth <input type="checkbox"/> Cesarean Birth <input type="checkbox"/> Additional Complications: <hr/>	<input type="checkbox"/> Hemorrhage <input type="checkbox"/> Symptoms of Shock <input type="checkbox"/> Elevated Blood Pressure <input type="checkbox"/> Tear or Laceration <input type="checkbox"/> Maternal fever <input type="checkbox"/> Inability to urinate ≥ 6 hours after delivery <input type="checkbox"/> Other (Please describe): <hr/> <hr/>	<input type="checkbox"/> Respiratory Distress/Cyanosis <input type="checkbox"/> Seizures <input type="checkbox"/> Abnormal temperature <input type="checkbox"/> Jaundice <input type="checkbox"/> Abnormal heart rate <input type="checkbox"/> Unable/Refuse to Feed <input type="checkbox"/> Congenital anomaly <input type="checkbox"/> Petechiae or bruising <input type="checkbox"/> Other (Please describe): <hr/> <hr/>	
INFORMATION ABOUT THE MIDWIFE			
Midwife’s Last Name*		Midwife’s First Name*	
Street Address	City	State	Zip Code