ARKANSAS DEPARTMENT OF HEALTH
LLM CASELOAD AND BIRTH LOG

FOR ADH USE ONLY			
Date Received			
By Mail		By Fax	.
# of Caseload Pages			
# of IR Pages			

Midwife Name_______________________________ Apprentice(s), Back-up LLM Name(s)_______________________________

Year__________ Report Dates _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Client Name	Estimated Due Date	Disclosure Form Signed	Left LLM Care for Non-Medical Reason	Lost Contact	Incident Report Required								Incident Report	Home Delivery	Hospital Delivery	Apprentice/s or other LLM Providing Care @ Birth
					Transfer Of Care Due to Medical Reason	Consult (C) Or Referral (R)	Consult (C) Or Referral (R)	Consult (C) Or Referral (R)	Consult (C) Or Referral (R)	Transport of Mother (M) Newborn (N) Both (B)	Hospitalization of Mother (M) Or Newborn (N) Within 30 days of Delivery	Informed Refusal Signed				
	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Initials