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 Phone: (501) 661-2480
Arkansas Department of Health Fax: (501) 661-2464
4815 W. Markham, Slot 16 Email: adh.whgen@arkansas.gov
Little Rock, AR 72205

*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)

INTRAPARTUM	**POSTPARTUM**	**NEWBORN**
☐ Prolonged or Arrested Labor ☐ Fetal Position other than Vertex ☐ Active Genital Herpes Lesions ☐ Labor prior to 37 weeks 0 days ☐ Bleeding in Labor ☐ Meconium ☐ Prolapsed Cord ☐ Non-reassuring Fetal Heart Rate ☐ Maternal Infection ☐ Suspected or Confirmed Fetal Death ☐ Maternal Elevated Blood Pressure ☐ Unknown GBS Status ☐ Other (Please describe): ____________________ **Outcome of Delivery:** ☐ Vaginal Birth ☐ Cesarean Birth ☐ Additional Complications: ____________________	☐ Hemorrhage ☐ Symptoms of Shock ☐ Elevated Blood Pressure ☐ Tear or Laceration ☐ Maternal fever ☐ Inability to urinate $\geq$ 6 hours after delivery ☐ Other (Please describe): ____________________ ____________________	☐ Respiratory Distress/Cyanosis ☐ Seizures ☐ Abnormal temperature ☐ Jaundice ☐ Abnormal heart rate ☐ Unable/Refuse to Feed ☐ Congenital anomaly ☐ Petechiae or bruising ☐ Other (Please describe): ____________________ ____________________

INFORMATION ABOUT THE MIDWIFE			
Midwife's Last Name*		Midwife's First Name*	
Street Address	City	State	Zip Code