

The Midwife Report provides centralized data management to help State Agencies with information-based administration of the midwives under their oversight. The Midwife Survey Tool stores data about midwife services regulated by the Arizona Department of Health Services (ADHS). This tool has been extended with supportive applications to maintain and analyze the submission and content of the midwife report.

About this Guide

The Midwife Report Guide gives you the information you need to:

- Ask questions relating to the structure and type of data used
- Determine required and conditionally required fields
- Use for valid field formats and limitations
- Understand and reference fields with specific rule considerations (Notes)

Note: This guide assumes that you are familiar with basic Windows and Internet operations and that you have read the Licensing of Midwifery Rules.

Conventions

This guide uses the following conventions:

Bold	Reference notes that highlight special considerations for the given field
*	Required questions that need at least one data field entered
<i>Italics</i>	References to Licensing of Midwifery Rules
REQUIRED	Specific fields within question which are required
Validation	Required format specifications

Midwife and Client Information - GUIDE

The following guide relates to the first page of the Midwife Survey.

Please contact the Division of Licensing regarding any questions at:

Email: AZLICENSE@azdhs.gov or phone: 602-364-2948 or 602-364-3048

Please visit <https://licensing.azdhs.gov/LicensingOnline/BSL> to submit a Midwifery Report

For first time users, please be aware that the registration process requires an approval by the Department, which will be processed within 24 hours of initial registration during regular business hours (Monday to Friday).

Please keep in mind that sessions expire automatically after 20 minutes of inactivity.

MIDWIFE SECTION

1. Midwife's name:

Pre-filled using registered credentials

2. Midwife's license number:

Pre-filled using registered credentials

MOTHER SECTION

*3. What is the mother's date of birth?

REQUIRED: Valid date in MM/DD/YYYY format

Validation: Mother must be between 13 and 65 years of age.

*4. Please provide a unique Client or Chart Number you will use to identify this mother and pregnancy.

REQUIRED: Midwife's Internal Unique Identifier **Note: Must be unique under the Midwife's specific license number**

*5. When was the mother's last menstrual period?

REQUIRED: Valid date in MM/DD/YYYY format; Used for estimating due date? (Y/N)

Validation: (Y)- Must be within the last 15 months; (N)- Must be within the last 5 years

*6. What is/was the mother's estimated due date?

REQUIRED: Valid date in MM/DD/YYYY format

Validation: Must be dated after the reported last menstrual period date (question 5).

*7. What is the mother's gravida and para?

REQUIRED: Both gravida and para fields

Validation: Gravida (1-20) Para (0-20); Gravida must be equal or greater than Para

*8. Please indicate if any of the following conditions apply:

REQUIRED: At least one option required (*multiple choices possible*)

Validation: Option [None] may not be selected when additional conditions are selected

Note: Any additional relevant condition(s) not listed may be included in any appropriate comments field box

*9. When did midwifery services end?

REQUIRED: Valid date in MM/DD/YYYY format

Validation: Reported date is compared to most other provided date fields; error messages state problematic issues

Note: Reported date must be within the last year and should not be 6 weeks past the date of delivery (if applicable)

*10. Did any of the following events occur?

REQUIRED: Determines need for a Demise Report (*If yes, report must be submitted within 5 days of demise*)

Only Required when a Demise from Question 10 is indicated

Demise Report – *Due within 5 days of demise* - GUIDE

The following guide relates to the DEMISE page of the Midwife Survey.

Please contact the Division of Licensing regarding any questions at:

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*11. You have indicated that the mother or infant expired, or there was a stillborn delivery. Please select all that occurred?

REQUIRED: Select all events that occurred

Validation: At least one option must be selected but stillborn and infant demise can't both be selected

*12. Provide a summary of the circumstances leading up to the events:

REQUIRED: Comments and dates

Validation: Comment Box; text up to 4000 characters

*13. Provide actions taken by the midwife in response to the event:

REQUIRED: Comments and dates

Validation: Comment Box; text up to 4000 characters

Transfer of Care? - GUIDE

The following guide relates to the TRANSFER OF CARE? page of the Midwife Survey.

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AZ Midwifery Regulations R9-16-101(47) defines "Transfer of care" as a midwife that refers the care of a client or newborn to an emergency medical services provider, a certified nurse midwife, a hospital, or a physician who then assumes responsibility for the direct care of the client or newborn.

*14. Did a Transfer of Care for either the client or the child occur at any time during midwifery care?

REQUIRED: Transfer of Care Indicator (*only one choice – Y/N*)

Note: If No, you will SKIP the Transfer of Care Information page

Only Required when a Transfer of Care from Question % (is indicated

Transfer of Care Information - GUIDE

The following guide relates to the TRANSFER OF CARE information page of the Midwife Survey.

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15. You have indicated that transfer of care was required.

NOT required: Comments and dates relating to transfer of care

Validation: Comment Box; text up to 4000 characters

Please provide any additional information:

*16. What was the method of transport?

REQUIRED: Midwife, EMS or Patient (*only one choice*)

*17. What was the transport destination?

REQUIRED: Hospital, EMS, Physician Office or Certified Nurse Midwife (*only one choice*)

*18. Please specify which hospital/physician office or the EMS/MW the care was transferred to.

REQUIRED: Specific location or individual, where or to whom midwife transfers the care

Validation: Alpha/numeric characters up to 1000 characters in length

*19. Please enter a date and time for:

REQUIRED: Transport Initiation (*if applicable; Arrival at Destination required*)

Validation: Valid date and time; compared to other reported dates; error messages state problematic issues

Note: EAP refers to the arrangements established by a midwife for a client's transfer of care in a situation in which the health or safety of the client or newborn are determined to be at risk. This plan should be implemented by calling emergency medical services provider, which is any governmental entity, quasi-governmental entity or corporation whether public or private that renders emergency medical services in this state Please refer to AZ Midwifery Regulations R9-16-108(D-F) for more information relating to EAP requirements and use.

*20. Did you use the Emergency Action Plan?

REQUIRED: EAP Indicator (*only one choice – Y/N*)

Note: If No, please skip to Question & ('fYmYX' c i h

- 21. If EAP was used, was the charge nurse notified in the EAP at onset of labor?

ONLY required for those indicating EAP was used in Question 21 (*only one choice – Y/*

N) Validation: [No] option must be specified and has limit of up to 100 characters

- 22. If yes, please enter the date and time:

ONLY required for those indicating charge nurse was notified at onset of labor in Question 22

Validation: Valid date and time

- 23. If EAP was used, was the charge nurse notified in the EAP at the completion of labor?

ONLY required for those indicating EAP was used in Question 21 (*only one choice – Y/N*)

Validation: [No] option must be specified and has limit of up to 1000 characters

- 24. If yes, please enter the date and time:

ONLY required for those indicating charge nurse was notified at completion of labor in Question 24

Validation: Valid date and time

*25. What was the medical reason for transfer of care?

REQUIRED: At least one option required (*multiple choices possible*)

Validation: [Condition from page 1] may not be selected if no condition indicated

Delivered by Midwife? - GUIDE

The following guide relates to the DELIVERED BY MIDWIFE? page of the Midwife Survey.

Please contact the Division of Licensing regarding any questions at:

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*27. Did you, the midwife, complete the delivery for this client?

REQUIRED: Delivery Indicator (*only one choice – Y/N*)

Note: If No, you will SKIP the Delivery information page

*8. For this pregnancy, please indicate whether the mother has ever had a history of or can be classified as the following?
REQUIRED: History of VBAC and/or Breech (*only one choice*)

Note: Additional delivery information on progress of labor will be required (if applicable)

Delivery Information - GUIDE

The following guide relates to the DELIVERY information page of the Midwife Survey.

Please contact the Division of Licensing regarding any questions at:

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28. You have indicated that the delivery was completed by the midwife.

Please provide any additional information:

NOT required: Comments and dates relating to the delivery

Validation: Comment Box; up to 4000 characters

29. If the mother had any of the conditions in question 8, please indicate the progress of labor for the current pregnancy:

ONLY required for those indicating VBAC and/or Breech history in Question 8: All fields required

Validation: First stage cm must be 0 to 10; Hour and minute fields must be entered for both first stage of labor and second stage of labor

*30. When was the delivery date?

REQUIRED: Infant's date of birth Validation: Valid date and time; compared to other reported dates; error messages state problematic issues

*31. What was the infant's gender?

REQUIRED: Male, Female or Not Yet Determined (*only one choice*)

*32. Please enter in the following infant measurements:

REQUIRED: All fields required using indicated scale (*grams or cm*)

Validation: Numeric characters only; up to 2 decimal places are accepted. Weight must 500 to 8000 grams; Length must be 25 to 70 cm; Head circumference must be 4 to 50 cm

*33. What was the weight for gestational age designation?

REQUIRED: AGA, SGA or LGA (*only one choice*)

Note: Appropriate for Gestational Age (AGA), Small for Gestational Age (SGA) or Large for Gestational Age (LGA),

*34. What were the infant's Apgar scores?

REQUIRED: Both 1 minute and 5 minute fields required

Validation: Numeric characters; integers 0 to 10 only

*35. Did any infant complications exist?

REQUIRED: Normal with No Complications, Preterm (under 36 weeks) or Abnormal/Complications (*only one choice*)

Note: If Abnormal/Complications, Question 36 is REQUIRED otherwise SKIP to Question 37

- 36. Please describe if the infant was "Abnormal/complications":

ONLY required for those indicating Abnormal/complications in Question 35

Validation: Comment Box; up to 4000 characters

*37. What was the filing date for the infant's birth certificate?

REQUIRED: File date on Birth Certificate Form

Validation: Valid date in MM/DD/YYYY format that is after delivery date but before or on today's date

38. What was the infant's birth certificate number? (*If available*)

NOT required: Birth certificate identifier issued by Vital Records

Additional Information - GUIDE

The following guide relates to the ADDITIONAL information page of the Midwife Survey.

Please contact the Division of Licensing regarding any questions at:

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*39. Was cord blood information provided?

REQUIRED: Yes or No (*only one choice – Y/N*)

Validation: [No] option must be specified and has limit of up to 1000 characters

*40. Was newborn screening information provided?

REQUIRED: Yes or No (*only one choice – Y/N*)

Validation: [No] option must be specified and has limit of up to 1000 characters

*41. Was hearing screening information provided?

REQUIRED: Yes or No (*only one choice – Y/N*)

Validation: [No] option must be specified and has limit of up to 1000 characters

*42. Was the first newborn screening completed?

REQUIRED: Yes, Mother declined, Referred to primary care provider or No (*only one choice*)

Validation: [No] option must be specified and has limit of up to 1000 characters

*43. Please enter the date that you obtained informed consent.

REQUIRED: Informed Consent date

Validation: Valid date in MM/DD/YYYY format

Note: "Informed consent" means a document signed by a client, as provided in R9-16-109, agreeing to the provision of midwifery services.

*44. Did the mother receive medical consultation?

REQUIRED: Yes or No (*only one choice – Y/N*)

Validation: [Yes] option must be specified and has limit of up to 1000 characters

45. Please include any additional information not included elsewhere:

NOT required: Comments and dates not appropriately fitting elsewhere

Validation: Comment Box; up to 4000 characters

Thank you! - GUIDE

The following guide relates to the THANK YOU information page of the Midwife Survey.

Please contact the Division of Licensing regarding any questions at:

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You **MUST** click on the
"DONE" button at the end of
the page to **SUBMIT** your
report.

This is also your confirmation page which will reflect the Midwife Client Number you reported on Page 1 and Question 4.