10/8/24njm

Trial of Labor After Cesarean Counselling Documentation

ANMC has been providing Trial of Labor After Cesarean (TOLAC) since the 1980's. Nationally, 60-80% of women who have tried a TOLAC have succeeded. We have anesthesia staff, a doctor for you, a doctor for the baby, nursing and operating room services available 24 hours per day. In the case of an unsuccessful TOLAC, I understand that the complications for both mother and baby are higher than they would be for a planned a cesarean delivery. If a tear in the uterus were to happen, injury to the baby may occur. We have specific plans to respond once a problem is detected. There are risks associated with every pregnancy. Risk can never be completely removed. We share the same goal as you: a healthy baby delivered to a healthy mom. We will make every effort to ensure this.

Among other topics I have reviewed these basic issues with my ANMC provider:

_ What are the implications of my future childbearing?

_ What increases and/or decrease the chance of success for vaginal ter cesarean (VBAC)?

_ What are the risks of TOLAC and/or planned cesarean birth.

Please initial on the lines:

_ I understand the benefits and risks with a planned cesarean delivery and TOLAC. I understand how these benefits and risks apply to me.

_ I understand the Birth Choices after Cesarean Delivery customer education material and to ask questions. My questions were answered to my satisfaction.

_ If I choose a TOLAC, this form will be reviewed again when I am admitted to the hospital and during the labor as indicated. I may want to ask for a repeat cesarean delivery or my doctor my find a need to deliver my baby by cesarean delivery.

My choice is (please check desired choice):

- O I have chosen to try a TOLAC for delivery of my baby.
- O I have chosen a planned repeat cesarean delivery of my baby.
- O I am undecided

Please sign and date: (For Telephone process see below)

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Counselling Documentation by telephone

Contact phone _____

Patient Signature _____ Date: _____

Provider Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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