

VAGINAL BIRTH AFTER CESAREAN (VBAC)

A vaginal birth after cesarean section (VBAC) is a trial of labor in a patient with a history of cesarean section or uterine scar from previous surgery as documented in the medical record, resulting in vaginal delivery.

Patient's
Initials

- _____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.
- _____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.
- _____ I understand that if I deliver vaginally, I will most likely have a shorter hospital stay than if I have a cesarean delivery.
- _____ I understand that during my VBAC, the use of oxytocin (Pitocin) hormone to make my uterus contract may be necessary to assist me in my vaginal delivery, and the risks and complications associated with this drug have been thoroughly explained to me.
- _____ I understand and accept that the most likely material risks and complications of a VBAC have been discussed with me and may include but are not limited to:
- *in the case of uterine rupture: internal and/or external bleeding may occur and may require blood transfusions and/or hysterectomy; and, there may not be sufficient time to operate and to prevent death or permanent brain injury to my baby*
 - *uterine rupture and possibility of maternal death*
- _____ I understand and accept that if a VBAC is unsuccessful, I may end up having a cesarean section, and also have a slightly greater risk of problems than if I had had a cesarean section without labor.
- _____ In the event of the need for a cesarean section, I understand and accept that the most likely risks and complications of a cesarean section have been discussed with me and may include but are not limited to:
- *blood clots*
 - *decreased bowel function*
 - *increased blood loss*
 - *infection and/or infection of the bladder or uterus*
 - *injury to the baby*
 - *injury to the urinary tract*
 - *pain or discomfort*
 - *risk of additional surgeries*
- _____ I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.
- _____ I understand and accept the risks of blood transfusion(s) that may be necessary.
- _____ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring but cannot control its ultimate appearance.
- _____ I am aware that smoking during the pre- and postnatal periods could increase chances of complications.
- _____ I have informed the doctor of all my known allergies.
- _____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.
- _____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.
- _____ I am aware and accept that no guarantees about the results of the procedure have been made.
- _____ I have been advised of the probable consequences of declining recommended or alternative therapies.
- _____ I have been informed of what to expect post-delivery, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.
- _____ The doctor has answered all of my questions regarding this procedure.

3/03
Revised 7/04, 9/05, 12/05, 1/06, 6/07

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, M.D., with associates or assistants of his or her choice, to perform a vaginal birth after a cesarean (VBAC) on _____ at _____.

(name of facility)

(patient name)

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician Signature/Date/Time

_____ copy given to patient
initial

_____ original placed in chart
initial

