NATIONAL MIDWIFERY GUIDELINES FOR CONSULTATION AND REFERRAL

4th EDITION

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DISCLAIMER

The National Midwifery Guidelines for Consultation and Referral (referred to as 'the Guidelines' throughout) provide information to assist midwives to integrate evidence and clinical judgment alongside of the preferences and needs of women for whom they are providing midwifery care. The Guidelines are intended to assist midwives

options while facilitating safe, evidence based maternity care within a woman-centred framework. It is important to note that the Guidelines are not intended as a guide to the most appropriate place for birth.

Consultation and Referral ("The Guidelines") have been a pivotal and essential resource for guiding clinical midwifery care. Although developed and informed by midwives for the purpose of informing midwifery practice, the Guidelines are applicable to all health care practitioners, across all contexts who will, or are likely to, provide care to women during the childbearing years.

The Guidelines foster a collaborative, multidisciplinary approach to the provision

The Australian College of Midwives (ACM) would like to acknowledge and thank the many organisations and individuals who have contributed to the 4th edition of the National Midwifery Guidelines for Consultation and Referral (the Guidelines).

This edition would not have been possible without the dedication and input from

to midwives and doctors who were seeking to provide individualised maternity

was no single, nationally consistent, evidence-based tool to guide midwives

well as the successful establishment of midwifery-led services.

1.3 Review and consultation

The ACM is committed to reviewing and updating the Guidelines regularly to ensure they remain evidence-based, comprehensive and usable. While the review process has varied slightly over time, the purpose has always been

Unit team at the Australian College of Midwives.

In 2020, the ACM established an Executive Steering Group to lead the 4th edition. This was followed by the distribution of an expression of interest (EOI) to all ACM members who could self-nominate to be engaged in the review process. The ACM received a large number of responses to the EOI.

Following a review of all responses to the EOI, members of the Executive

lead the four Clinical Reference Groups (CRGs). The four leads where then assigned one of the four existing indication sections from the third edition of the Guidelines to review and update. Terms of reference for each of the CRGs were developed and distributed to the Chairs. Candidates from the pool of EOI applications were then chosen to join the four CRGs.

Chairs of the CRGs were provided with proformas which ensured that changes, additions and any relevant evidence could be captured throughout the review process. Multiple meetings between the Chair of the Executive Steering Committee and the Chairs of the CRGs occurred throughout 2020.

Following review and updates made by the CRGs, the guidelines were reviewed by the Executive Committee Chair and collated in preparation for consultation.

The consultation process was a phased approach. The phases are detailed below:

1. Maternity care stakeholders including midwives, doctors, health service

   opportunity to provide feedback through an online survey. Feedback

   received informed changes to the levels of consultation and referral and the inclusion of any additional indications.

2. Following minor changes, the guidelines were distributed for public consultation. The public consultation began in early 2021 and lasted for

   Research Council (NHMRC) guidelines for public consultation.

3. A legal review of Appendices A, B and C was completed. Amendments to the appendices were made in response to this review.

4. All feedback, comments and suggestions were then collated and used to

   review by the Executive Steering Committee.

   endorsement.

section to be added to the Guidelines. This was supported by feedback received

capture additional considerations in the provision of maternity care that were not

References

Australia.

https://doi.org/10.1186/1471-2393-11-82

3 Beasley S, Ford N, Tracy SK, Welsh AW. (2012). Collaboration in Maternity Care is achievable and practical. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, DOI: 10.1111/ajo.12003

3. If problems occur during pregnancy, birth or the postnatal period, the

4.1 The Levels of Consultation and Referral Explained

recommended that the midwife use their clinical judgement and the following guidance to determine the appropriate level of consultation and / or referral.

Important notes related to level of consultation or referral:

- **Where there are variations in the severity of a condition, more than one**

4.2.3 The midwife may choose to discuss clinical situations with a midwifery colleague, medical practitioner, and / or health care provider, but this is not indicated. Such a discussion does not transfer the responsibility for care. Any discussion had should be clearly documented.

4.3 Consult

Table 4.3: Level B - Consult

LEVEL	DESCRIPTION	GUIDANCE
B	Consult	Consult with a relevant medical practitioner or other health care provider.

4.3.1 Following a discussion with the woman about the need for consultation

to initiate consultation with a medical practitioner (or other health care provider), as indicated. The midwife must clearly communicate and document the indication(s) that require consultation with a relevant medical practitioner or other health care provider.

4.3.2 If the woman declines consultation, the midwife must follow the 'ACM position statement about caring for women who make choices outside professional advice' (See appendix B) and where necessary, seek additional professional advice (legal or otherwise).

4.3.3 A consultation with a medical practitioner or other health care provider may be:

for consultation, OR

b) Between the midwife and the medical practitioner (or other health care provider) where the woman is unable or chooses not to attend. In this situation, the consultation is undertaken by the midwife, on behalf of the woman.

4.3.4 The consultation may occur:

a) in person
b) by telephone
c) by telehealth
d) by other electronic means, OR
e) a combination of any of the above.

4.3.6 The outcome of the consultation must be documented in the woman's handheld pregnancy record, clinical notes and / or via electronic means as determined by local policy or protocol.

4.3.7 Seeking consultation per the Guidelines does not automatically transfer the midwife's responsibility of care to the health professional who has been consulted.

4.3.8 The midwife will continue to provide maternity care to the woman and coordinate such care in consultation with the medical practitioner and / or other health care provider.

4.3.9 Where consultation occurs, the ongoing responsibilities of the midwife, medical practitioner and / or other health care providers, including how they will collaborate with the woman and among each other, must be discussed.

4.3.10 If the medical practitioner's assessment of the clinical issue or situation is such that the woman's ongoing care requires responsibility to be transferred to the medical professional, the woman will be included in all discussions and provide informed consent prior to the transfer of care. The midwife will remain a key member of the multidisciplinary health care team where referral is indicated.

4.4 Refer

Table 4.4: Level C - Refer

LEVEL	DESCRIPTION	GUIDANCE
C	Refer	Refer a woman and / or her baby to a relevant medical practitioner or other health care provider.

4.4.1 When maternity care is referred (either permanently or temporarily) from the midwife to a medical practitioner, that medical practitioner, in consultation with the woman, assumes responsibility for maternity care.

4.4.2 The woman must provide informed consent prior to any transfer of care. This will include a discussion about appropriate timing, nature of the transfer, ongoing involvement of the midwife in providing midwifery care and the possibility of care being transferred back to the midwife where the clinical condition(s) permit.

4.4.3 The midwife will continue to provide midwifery care for the woman, working in partnership and collaboration with the medical practitioner and other members of the multidisciplinary team, even in the event that a medical practitioner (or other health care provider) assumes primary responsibility for the care of the woman.

4.4.4 If the indication or reason for referral is resolved, the woman may be referred back to the midwife, for ongoing maternity care. This will be following a discussion with the woman and only after her informed consent.

4.4.5 The outcome of the referral must be documented in the woman's handheld pregnancy record, clinical notes and / or via electronic means as determined by local policy or protocol.

Regardless of the nature or level of discussion, consultation or referral, communication between members of the multidisciplinary team about changes to care plans should always include the woman and be clearly documented and communicated to all parties involved.

Table 4.4 Summary of levels and associate care provider responsibilities

LEVEL	DESCRIPTION	CARE PROVIDER WITH PRIMARY RESPONSIBILITY
A / A*	Discuss	The midwife assumes primary responsibility for the maternity care of the woman. (Note: the midwife may discuss clinical situations with a midwifery colleague, medical practitioner, and / or health care provider, but this is not indicated).
B	Consult	The midwife will consult with a medical practitioner or other health care provider as indicated but only after the woman has provided consent. The indications for consultation will be reviewed and evaluated and used to inform the provision of care. The midwife will continue to provide midwifery care to the woman in collaboration with the medical practitioner 0091(or)10.551o*et0with a mie78e.01302(f)26.0064(e

	Other cardiac disease	**B / C**
6.1.4	Dermatological diseases requiring systemic therapy	**B**
6.1.5	Drug dependence or misuse	
	Alcohol dependency	**B / C**
	Illicit or prescribed drug dependency	**B / C**
6.1.6	Endocrine	
	Addison's disease, Cushing's disease or other endocrine requiring treatment	**C**
		C
	Newly diagnosed Type I and II diabetes	**C**
	Gestational Diabetes Mellitus in a prior pregnancy	

Hepatitis C	**B**
Cytomegalovirus	**C**
	B
Chlamydia	**A* / B**
Genital herpes – primary infection	**B**
Genital herpes – recurrent infection	**A* / B**
Syphilis – positive serology and treated	**A / B**
Syphilis – positive serology and not yet treated	**C**
Trichomoniasis	**A* / B**
Gonorrhoea	**B**
	A / B
HIV infection	**C**
Listeriosis	**B**
	C
	A / B
Rubella	**C**
	C
Tuberculosis - active	**C**
Tuberculosis – past history and treated	**B**
Hepatitis A / B / C / D / E	**A / B / C**
History of pre-pregnancy	

	Urinary tract infections (UTI) - current	**A / A* / B**
	UTI – past history of recurrent	**A / B**
	Other renal	**B**
6.1.17	Respiratory Disease	
	Asthma well controlled	**A**
	Asthma partly controlled	**B**
	Asthma poorly controlled	**B / C**
	H1N1	**C**
	Severe lung function disorder	**C**
	Sarcoidosis	**C**
	History of Covid-19 (history of past infection)	**B**
		C
		B

Previous maternity history

6.3 Antenatal

6.4 Intrapartum

6.4.1	Caesarean section		
	Classical / midline incision	**B / C**	
	T incision	**B / C**	
	Lower segment caesarean section	**B**	
	Two or more previous caesarean sections (no history of vaginal birth)	**B / C**	
	Two or more previous caesarean sections (history of vaginal birth / successful VBAC)	**B / C**	
6.4.2	Forceps or vacuum birth		

6.5 Postpartum

6.6 Neonatal

6.7 History of psychological or mental health

6.8 Other considerations

	fetal heart rate, meconium stained liquor, signs of infection as examples	**B/C**
	Rupture of membranes with known GBS or previous history of baby with early-onset GBS	**B/C**
8.1.28	Shoulder dystocia	**B/C**
8.1.29	Third or fourth degree perineal tear	**C**
8.1.30	Unengaged head in active labour	
		B
	Multipara	**A/B**
8.1.31	Uterine inversion	**C**
8.1.32	Uterine rupture	**C**
8.1.33	Vasa praevia	**C**

9 CLINICAL INDICATIONS DURING THE POSTPARTUM PERIOD

9.1.7	Prolapse	
	Uterine	**C**
	Cystocele	**C**
	Rectocele	**C**
9.1.8	Pulmonary embolism	**C**
9.1.9	Stroke	**C**
9.1.10	Substance use / misuse	**A / A* / B / C**
9.1.11	Suspected or actual maternal infection	
		A* / B
	Mastitis	**A* / B**
	Urinary tract infection	**A / A* / B**
		B / C
	Wound infection – e.g., caesarean incision, perineal, episiotomy	**B**
	Suspected retained placenta	**B / C**
	Sepsis	**C**
9.1.12	Thrombophlebitis or thromboembolism	**C**

9.2 Newborn

9.2.1	**Abnormal finding on newborn examination**	**B**
9.2.2	Birth injury / trauma requiring investigation	**B / C**
9.2.3	Birth weight • **Use centile charts to gestation** • •	**C**
9.2.4	Congenital abnormalities	**C**
9.2.5	Failure to pass urine or meconium within 24 hours of birth	**A / B**
9.2.6	Failure to pass urine or meconium within 36 hours of birth	**B**
9.2.7	Faltering growth **Including**: • **Weight** • **Head ciTd[(H).**	

10 SOCIAL INDICATIONS

10.1.1	Adoption	A / B
10.1.2	Current or previous child protection concerns	A*, A / B
10.1.3	Family / domestic violence	B
10.1.4	Financial issues	B
10.1.5	**Identified asylum seeker status**	A / B
10.1.6	**Identified homelessness**	A / B
10.1.7	**Identified migrant status**	A / B
10.1.8	**Identified refugee status**	A / B
10.1.9	Incarceration	A / B
10.1.10	Lack of social support	B
10.1.11	Legal matters	A / B
10.1.12	Learning disabilities	A / B
10.1.13	Pregnancy during teenage years	A / B
10.1.14	Recent stressful event	A / B
10.1.15	**Recent significant loss**	A / B
10.1.16	**Significant social isolation**	B
10.1.17	Unemployment	A / B
10.1.18	**Other identified vulnerabilities**	A / B / C

The ACM respects and supports a woman's autonomy and right to make decisions regarding her care following consideration of her needs and beliefs,

assist midwives to continue to provide midwifery care when a woman chooses a course of action against advice or outside the Guidelines.

Background

The principles that underpin health care and health law both emphasise the

In the first instance

When a woman chooses care outside the recommendations provided in the Guidelines, the midwife must attempt to discuss with the woman (and with any

of the woman's decision. As part of that discussion, it is important to understand the woman's reasoning and the basis for her decision, and to explain why the woman's decision is inconsistent with the Guidelines. It is also important to explore available options and possible resolutions, within midwifery professional standards, to address the woman's needs.

- **If this does not resolve the issues to the satisfaction of both the woman and midwife, the following approach is recommended.**

If the matter remains unresolved

If a midwife advises a woman that a certain course of action should be followed

decision to choose a pathway of care that carries increased risk of harm to either the woman or her baby.

Similarly, the midwife must ensure the decision to discontinue care is not used coercively, but that it adequately conveys the gravity of the midwife's concern.

The midwife should notify his or her insurer, if appropriate, of any changes in circumstances.

If care continues

If the midwife decides to continue care, the midwife must:

a. **Continue to inform the woman about changes in indications health and wellbeing for her and / or her baby(s).**
b. **Continue to make recommendations for safe care consistent with the Guidelines and any relevant broader evidence base.**
c. **Engage other caregivers who have or who may become involved in providing advice or care (e.g., obstetricians, general practitioners, hospital-based midwives and / or other midwives).**

outside the midwife's scope of practice or competence.

e. **Document all discussions and decisions.**

If care is discontinued

If the midwife decides to discontinue care, the midwife must:

a. **As soon as possible, clearly communicate his or her inability to continue to provide care to the woman, and the reasons why that midwifery care is being discontinued.**

2. If in a hospital setting, inform the midwife in charge and / or call a medical practitioner.
3. Continue to inform the woman about any changes in indications of her or her baby's health and wellbeing.
4. Call the second midwife to attend. The second midwife should maintain his or her own contemporaneous notes documenting the care being provided, discussions and decisions.
5. Attempt to provide care within midwifery standards of practice, and otherwise provide care to the best of his or her ability.
6. Access appropriate resources and / or personnel to provide any needed care.

Continue to document all care provided, as well as discussions and decisions (documentation should include the date and time along with the name and status of all persons involved).

12 APPENDIX B: RECORD OF UNDERSTANDING[14]

It is recommended that this form is completed when a woman chooses care outside these Guidelines or against the advice of her midwife.

There are three parts in the Record of Understanding:

Between (woman)	
And (midwife)	
On (date)	
At (address)	

14. This form will be updated from time to time. For a copy of the most recent version of this form and the accompanying explanatory notes, go to www.midwives.org.au

PART 1: Record of advice / discussions

To be completed by the woman	To be completed by primary midwife
What option(s) are you conside,7are9.35 lS37e wtou e ion aom he wps) ?]TJ-116.287 -25.0341 rd[(Wha)3.99102(t , i)21.016.(1n)]1.9902(oy)4.98 9(y,)27.90047(v12.9931(alues,)]TJT*[(cin5.9892.( )26.08071(orm)4.10169(fion, e1	

In this section, outline the agreement you have reached with the woman about her ongoing care. Specify each care provider's role.		
[Tick all that apply]		
Midwife lead carer **Name**:	**Name**:	**Other (please specify)** **Name**:

Reasons for decision to continue midwifery care
Conditions / restrictions imposed on continued care
Conditions upon which midwife may revisit the decision to continue care
Declaration by the woman: **I, , have read and** **I have had the opportunity to ask questions and discuss possible alternatives.** **midwife has concerns that we have not been able to resolve, and I agree to continued care by the midwife on the terms stipulated above. I understand that I am free to change my mind at any time and I will notify my midwife in that event at the earliest opportunity.**
(Signed by woman) / /
(Signed by midwife) / /

3.2: DECLARATION FOR DISCONTINUATION OF CARE WHERE THE MIDWIFE HAS ELECTED TO DISCONTINUE CARE.

This declaration is to be completed by the midwife where agreement on an alternative care plan has not been reached.

NOTE: In the course of labour or in urgent situations, the midwife is obliged to attend the woman.[15]

13 APPENDIX B: MAKING A REFERRAL

It is strongly recommended that midwives provide a referral letter either in the clinical record or separately by letter when making a referral. It is expected that healthcare providers will communicate with the midwife in writing about their

of care. This is an accepted convention of communication across health care.

A referral letter should contain demographic details and all relevant clinical information that is appropriate, as well as the midwife's contact information. The midwife should indicate whether she / he will provide ongoing midwifery care.

SAMPLE referral letter

Date:
Obstetric Clinic / Hospital Address:

Dear Consultant

Re: **Woman's name ("Jennifer Jones") DOB**: __ / __ / __ **ID #**
Address:

Thank you for seeing "Jennifer Jones" who is now ## weeks pregnant. She requires review because of her previous caesarean section. Her history is as follows:

- **Date**: **## weeks. ## onset of labour, # hours duration, ## wt ###g boy**
- **Date**: **## 40 weeks. IOL for pre-eclampsia. Unsuccessful IOL after three days, caesarean section performed. 3575g boy.**

Both of these pregnancies were assisted conceptions.

This time Jennifer spontaneously conceived, and her due date is xx / xx / xx. She is keen to pursue VBAC for this birth but was told at a consultation very early in this pregnancy that she should have elective LSCS at 38 weeks.

[Include any further relevant information.]

We look forward to discussing this with you at the clinic appointment. Jennifer's pregnancy has been straightforward this time, notably her blood pressure has remained stable and normal, and she has had no proteinuria or oedema. She is currently taking some iron to boost her stores. This baby is growing well, and movements are reassuring.

I have included a copy of her blood and US scan results for you.

Kind regards

Midwife's signature
Midwife's name, Midwife's registration number
Contact details.[16]