

**R9-16-106. R9-16-108. Responsibilities of the Licensed Midwife; Scope of Practice**

- A. A midwife shall provide care only to clients determined to be low risk.
- B. Except as provided in R9-16-109(B), (C) or (D), a midwife may perform:
  - 1. A vaginal delivery after prior Cesarean section;
  - 2. A delivery with multiple gestation; or
  - 3. A delivery of a fetus in a breech presentation.
- C. Prior to providing care to a client requiring a delivery specified in subsection (B), a midwife shall:
  - 1. Ensure that a client consults with a physician (refer to ARS) who has a medical specialty in obstetrics and gynecology;
  - 2. Ensure a Department-provided form is completed that includes:
    - a. The physician's:
      - i. Name,
      - ii. License number including an identification of the physician license type,
      - iii. Office address on file with the physician's licensing board,
      - iv. Telephone number on file with the physician's licensing board, and
      - v. E-mail address;
    - b. The midwife's:
      - i. Name,
      - ii. Telephone number,
      - iii. License number, and
      - iv. E-mail address;
  - 3. Ensure a Department-provided form is completed by the physician that includes:
    - a. The client's:
      - i. Name;
      - ii. Whether the physician consultation was in-person, telephonic, or electronic;
      - iii. Date of birth;
      - iv. Obstetric history, including gravida/para, estimated date of confinement, and weeks gestation; and
      - v. Client's information about Cesarean section, multiple gestation, and breech history;
    - b. The physician's printed name;

- c. An initialed statement that the physician has conducted an in-person, telephonic, or electronic discussion with the client prior to 30 weeks gestation and appropriate to the client's specific condition and date conducted;
- d. A statement, initialed by the physician, that the physician has reviewed the client's medical records related to the current pregnancy, including medical records from previous pregnancies;
- e. A statement, initialed by the physician, that the physician has explained to the client the potential risks, adverse outcomes, and alternatives to an at-home delivery associated with the client's specific condition, including the need for emergency transport, surgical intervention, and the potential for neonatal and maternal complications, including death;
- f. A statement, initialed by the physician, that the physician has reviewed the midwife's emergency action plan developed for the client, as required in (C)(6);
- g. A statement, initialed by the physician, that the physician's review of the midwife's emergency action plan, as required in (C)(6), does not make the physician responsible for the client's medical care;
- h. A statement, initialed by the physician, of whether the physician believes that the client is appropriate for an at-home delivery;
- i. An attestation from the physician that:
  - i. Provides the physician's printed name;
  - ii. States the information provided in the Department-provided form is true and correct;
  - iii. States the physician is not approving or denying an at-home delivery for the client, and that the client may decide to proceed with an at-home delivery, regardless of the physician consultation;
  - iv. Acknowledges that the physician is not responsible for the client's medical care, unless the physician agrees to take over the management of the client's medical care; and
  - vi. Is signed and dated by the physician;
- k. An attestation from the client that includes:
  - i. The client's name and date of birth;
  - ii. The referring midwife's name, telephone number, and license number;
  - ii. The physician's name;



3. The required tests and potential risks to a newborn if refused and the need for written documentation of client's refusal;
  4. The use of a physician or medical facility for the provision of emergency consultation or services;
  5. The midwife's facilitation of the transfer of care to the physician or medical facility; and
  6. The midwife's termination of care should certain medical conditions arise or the client refuses intervention.
- E. A midwife shall obtain written informed consent signed by the client upon acceptance for midwifery care.
- ~~B.F.~~ A midwife shall maintain all instruments used for delivery in an aseptic manner and other birthing equipment and supplies in clean and good condition.
- ~~C.G.~~ A midwife shall both initially and periodically thereafter assess a client's physical condition in order to establish the client's continuing eligibility to receive midwifery services.
- ~~D.~~ ~~A midwife shall inform clients, both orally and in writing, of the midwife's scope of practice; the risks and benefits of home birth; the required tests and potential risks to a newborn if refused, and the need for written documentation of client's refusal; the use of a physician or medical facility for the provision of emergency consultation or services; midwife facilitation of the transfer of care to the physician or medical facility; and the midwife's termination of care should certain medical conditions arise or the client refuses intervention. A written informed consent shall be signed by the client upon acceptance for midwifery care.~~
- ~~E.H.~~ A midwife shall provide initial initial care and care during the prenatal period shall be provided as follows:
1. Schedule or order The the following tests shall be scheduled or ordered during the first visit:
    - a. Blood type, including ABO and Rh, with antibody screen;
    - b. Urinalysis;
    - c. Hematocrit, and hemoglobin, or complete blood count, initially and rechecked at 28 to 36 weeks of the pregnancy;
    - d. Syphilis, gonorrhea, HIV, hepatitis, and chlamydia testing, unless a written refusal for ~~gonorrhea or chlamydia testing~~ is obtained from the client; and
    - e. Rubella titer; ~~and~~
    - f. ~~One hour blood glucose screening test for diabetes, between 24 to 28 weeks of the pregnancy.~~

2. Conduct Prenatal prenatal visits shall be conducted at least every 4 weeks until 28 weeks gestation, every 2 weeks from 28 weeks until 36 weeks gestation, and weekly thereafter and each shall include:
  - a. The taking of weight, urinalysis for protein, nitrites, glucose and ketones, blood pressure, and assessment of the lower extremities for swelling;
  - b. Measurement of the fundal height and listening for fetal heart tones and, later in the pregnancy, feeling the abdomen to determine the position of the fetus;
  - c. Referral of a client, as appropriate, for ultrasound or other studies recommended based upon examination or history;
  - d. Recommendation of administration of the drug RhoGam to unsensitized Rh negative client after 28 weeks, or any time bleeding or invasive uterine procedures are done, ~~or midwife administration of RhoGam under physician's written orders;~~
  - e. Fetal movement counts by client beginning at 28 weeks gestation; and
  - f. One-hour blood glucose screening test for diabetes, between 24 to 28 weeks of the pregnancy.
3. Referal a client for:
  - a. At least one ultrasound to determine placental location and risk for placenta previa and placenta accrete for a vaginal birth after prior Cesarean section delivery;
  - b. A follow-up ultrasound at 35-36 weeks to confirm fetal presentation and estimated fetal weight for a breech pregnancy; or
  - c. An early ultrasound to confirm amnionicity and chorionicity and a follow-up growth ultrasound for a pregnancy with multiple gestation.
- 3.4. Monitor Fetal fetal heart tones with fetoscope and documentation of first quickening, ~~shall begin~~ between 18 and 20 weeks gestation, and conduct weekly visits ~~shall be conducted~~ until these signs have occurred. If these signs do not occur by 22 weeks gestation, medical consultation shall be initiated.
- 4.5. Conduct A a visit ~~shall be made~~ to the client's home prior to 35 weeks gestation to ensure that the birthing environment is appropriate for birth and that a working telephone or citizen's band radio is available.
- F.I. A midwife shall provide Care care during the intrapartum period ~~shall be provided~~ as follows:
  1. The midwife shall initially determine if the client is in labor and the appropriate course of action to be taken by:

- a. Assessing the interval, duration, intensity, location, and pattern of the contractions;
  - b. Determining the condition of the membranes, whether intact, ruptured, and the amount and color of fluid;
  - c. Evaluating the presence of bloody show;
  - d. Reviewing with the client the need for an adequate fluid intake, relaxation, activity, and emergency management; and
  - e. Deciding whether to go to client's home, remain in telephone contact, or arrange for transfer of care or consultation.
2. During labor, the midwife shall assess the condition of the mother-client and fetus ~~shall be assessed~~ upon initial contact, every half hour in active labor until completely dilated, and every 15 to 20 minutes during pushing, ~~after the bag of water has ruptured~~ following rupture of the amniotic bag, or until the newborn is delivered. Care shall include the following:
- a. Checking of vital signs every 2 to 4 hours and an initial physical assessment of the client;
  - b. Assessment of fetal heart tones every 30 minutes in active first stage labor, and every 15 minutes during second stage, following rupture of the amniotic bag or with any significant change in labor patterns;
  - c. Periodic assessment of contractions, fetal presentation, dilation, effacement, and position by vaginal examination;
  - d. Determination of the progress of active labor for primiparas by determining if dilation occurs at an average of 1 cm/hr until completely dilated, and a second stage not to exceed 2 hours;
  - e. Determination of a normal progress of active labor for multigravidas by determining if dilation occurs at an average of 1.5 to 2 cm/hr until completely dilated, and a second stage not to exceed 1 hour;
  - f. Maintenance of proper fluid balance for the client throughout labor as determined by urinary output and monitoring urine for presence of ketones, at least every 2 hours; and
  - g. Assisting in support and comfort measures to the client and family.
3. After delivery of the newborn, care shall include the following:
- a. Assessment of the newborn at 1 minute and 5 minutes to determine the Apgar scores;

- b. Physical assessment of the newborn for any abnormalities;
  - c. Inspection of the client's perineum for lacerations; and
  - d. Delivery of the placenta within 40 minutes during which time the midwife shall assess for signs of separation, frank or occult bleeding, examine for intactness, and determine the number of umbilical cord vessels.
4. The responsibility of the midwife shall include recognition of and response to any situation requiring immediate intervention.

G.J. A midwife shall provide the following care during the postpartum period:

1. During the ~~immediate postpartum period~~ of 2 hours after delivery of the placenta, care of the client shall include:
  - a. Taking of vital signs of the client with external massage of the uterus and evaluation of bleeding every 15 to 20 minutes for the first hour and every half hour for the second hour;
  - b. Assisting the client to urinate within 2 hours following the birth;
  - c. Evaluating the perineum for tears, bleeding, or blood clots;
  - d. Assisting with maternal and infant bonding;
  - e. Assisting with initial breast feeding, instructing the client in the care of the breast, and reviewing potential danger signs, if appropriate;
  - f. Providing instruction ~~and support~~ to the family ~~to ensure~~ about adequate fluid and nutritional intake, rest, and ~~type the types~~ of exercise allowed, normal and abnormal bleeding, bladder and bowel function, appropriate baby care, signs and symptoms of postpartum depression, and any danger signals with appropriate emergency phone numbers;
  - g. Recommending the drug RhoGam or ~~administering it, under written physician's orders~~, document the administration of RhoGam in the client's record to an unsensitized Rh-negative client who delivers an Rh-positive newborn. Administration shall occur not later than 72 hours after birth.
2. During the immediate postpartum period of 2 hours after delivery of the placenta, care of the newborn shall include:
  - a. Perform a newborn physical exam to determine the newborn's gestational age and any abnormalities;
  - b. Apply erythromycin optic ointment or other preparation ~~specifically approved by the Director~~ to each of the newborn's eyes in accordance with A.A.C. ~~R9-6-718~~ R9-6-332; and

- c. ~~Recommend or administer Vitamin K under physician's written orders document the administration of Vitamin K to the newborn in the newborn's record to the newborn.~~ Administration shall occur not later than 72 hours after birth.
- 3. Any abnormal or emergency situation shall be evaluated and consultation or intervention sought in accordance with these rules.
- 4. The condition of the client and newborn shall be re-evaluated between 24 and 72 hours of delivery to determine whether the recovery is following a normal course and shall include:
  - a. Assessment of baseline indicators such as the client's vital signs, bowel and bladder function, bleeding, breasts, feeding of the newborn, sleep/rest cycle, activity with any recommendations for change;
  - b. Assessment of baseline indicators of well-being in the newborn such as vital signs, weight, cry, suck and feeding, fontanel, sleeping, bowel and bladder function with documentation of meconium, and any recommendations for changes made to the family;
  - c. Submission of blood obtained from a heel stick to the newborn to the ~~Regional Genetic Screening Laboratory, P.O. Box 17123, Denver, Colorado 80217, Arizona State Laboratory~~ for ~~metabolic screening for common genetic disorders, within 72 hours of the birth~~ laboratory screening according to 9 A.A.C. 13, Article 2, unless a written refusal is obtained from the client and documented in the newborn's record.
  - d. Recommendation to the client to secure medical follow-up for her newborn; and
  - e. Advice on the necessity of family planning interventions for the couple.

H.K. The midwife shall file a birth certificate with the local registrar within seven days after the birth of the newborn.

**R9-16-108. R9-16-109. Prohibited Practice; Transfer of Care**

- A. ~~A licensed midwife shall not accept for care and a woman who has or shall not during pregnancy, labor and delivery, and postpartum knowingly continue to provide care caring to, and shall immediately transfer care of, any women who has or~~ for a client that develops any of the following ~~conditions or circumstance:~~
  - 1. A previous ~~Cesarean section or other known~~ uterine surgery;
  - 2. A history of severe postpartum bleeding, of unknown cause, which required transfusion;
  - 3. Deep vein thrombophlebitis or pulmonary embolism;

4. Insulin-dependent diabetes, hypertension, heart disease, kidney disease, blood disease, Rh disease with positive titers, active tuberculosis, or active syphilis;
5. Active hepatitis or active gonorrhea until treated and recovered, following which midwife care may resume;
6. An unsafe location for delivery;
7. A blood pressure of 140/90 or an increase of 30mm Hg systolic or 15mm Hg diastolic over client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart;
8. A persistent hemoglobin level below 10g or a hematocrit below 30 during the third trimester;
9. Primary genital herpes simplex infection in the first trimester or ~~has~~ active genital herpes at the onset of labor;
10. A pelvis that will not ~~safely~~ safely allow a baby to pass through during labor;
11. A severe psychiatric illness evident during assessment of client's preparation for birth, or a history of severe psychiatric illness in the six-month period prior to pregnancy;
12. An addiction to alcohol, narcotics, or other drugs;
13. Prematurity or labor beginning before 36 weeks gestation;
14. ~~Multiple gestation in the current pregnancy;~~
- ~~15-14.~~ Gestational age greater than 34 weeks with no prior prenatal care;
- ~~16-15.~~ A gestation beyond 42 weeks;
- ~~17-16.~~ Presence of ruptured membranes without onset of labor within 24 hours;
- ~~18-17.~~ Abnormal fetal heart rate of below 120 beats per minute or above 160 beats per minute;
- ~~19-18.~~ Presence of thick meconium, blood-stained amniotic fluid, or abnormal fetal heart tones;
- ~~20-19.~~ A postpartum hemorrhage of greater than 500cc in the current pregnancy;
- ~~21-20.~~ A nonbleeding placenta retained more than 40 minutes; and
- ~~22-21.~~ Expressed wishes of the client or family.

B. A midwife shall not perform a vaginal delivery after prior Cesarean section for a woman who:

1. Had more than one previous Cesarean section;
2. Had a previous Cesarean section with a classical or vertical uterine incision;
3. Had a previous Cesarean section within 18 months prior to current delivery;
4. Had a previous Cesarean section for any of the following indications:
  - a. Failure to progress.
  - b. Failure to dilate.
  - c. Cephalopelvic disproportion, or

- d. Anything else?
  - 5. Had complications during a previous vaginal delivery after a Cesarean section;
  - 6. Had a Cesarean section with complications, including:
    - a. Uterine infection, or
    - b. Anything else?
  - 7. Has a fetus experiencing fetal anomalies, confirmed by an ultrasound; or
  - 8. Has any other known complication of the current pregnancy.
- C. A midwife shall not perform a vaginal delivery with multiple fetuses for a woman who:
  - 1. Has more than 2 fetuses;
  - 2. Has twins who are less than 37 weeks gestation or more than 41 weeks gestation;
  - 3. Has either twin not presenting in a vertex position;
  - 4. Has either twin experiencing atypical growth;
  - 5. Has either twin experiencing fetal anomalies, confirmed by an ultrasound;
  - 6. Had a previous Cesarean section or other demonstration of an inadequate maternal pelvis;  
or
  - 7. Has any other known complication of the current pregnancy.
- D. A midwife shall not perform a vaginal breech delivery for a woman who:
  - 1. Has a more than one fetus;
  - 2. Has a fetus with an estimated fetal weight less than 2500g or more than 3800g;
  - 3. Has a fetus in a footling or incomplete breech position;
  - 4. Has a fetus experiencing fetal anomalies, confirmed by an ultrasound;
  - 5. Had a previous unsuccessful vaginal delivery or other demonstration of an inadequate maternal pelvis; or
  - 6. Has any other known complication of the current pregnancy.
- ~~B-E.~~ A midwife shall not perform any operative procedures except as provided in R9-16-110.
- ~~C-F.~~ A midwife shall not use any artificial, forcible, or mechanical means to assist birth, nor shall the midwife attempt to correct fetal presentations by external or internal movement of the fetus.
- ~~D.~~ ~~A midwife shall not administer drugs or medications except as provided in R9-16-110 and R9-16-106(E)(2)(d), (G)(1)(g), and (G)(2)(e).~~
- ~~E-G.~~ A midwife shall not knowingly continue and shall transfer care of any newborn in whom any of the following conditions are present:
  - 1. Birth weight less than 2000 grams;
  - 2. Pale, blue, or gray color after 10 minutes;
  - 3. Excessive edema;

4. Major congenital anomalies; or
5. Respiratory distress.

**R9-16-109. R9-16-110. Required Consultation During Pregnancy [Rename?]**

A. The midwife shall obtain medical consultation to obtain a recommendation for treatment, referral, or transfer of care at the time ~~any~~ a client is determined to have any of the following ~~circumstances or conditions~~ during the current pregnancy:

1. Testing positive for HIV, syphilis, gonorrhea, or hepatitis;
2. History of seizure disorder;
3. History of stillbirth, premature labor, or parity greater than 5;
4. Age ~~is~~ is younger than 16 years of age or a primigravida older than 40 years of age;
5. Failure to auscultate fetal heart tones by 22 weeks gestation;
6. Refusal of Rh blood work or treatment;
7. Failure to gain 12 pounds by 30 weeks gestation or gaining more than 8 pounds in any two-week period during pregnancy;
8. Severe, persistent headaches, with visual disturbances, stomach pains, or swelling of the face and hands;
9. Greater than 1+ sugar, ketones, or protein in the urine on two consecutive visits;
10. Excessive vomiting or continued vomiting after 20 weeks gestation;
11. Symptoms of decreased fetal movement;
12. A fever of at least or greater than 100.4° F or 38° C twice at **24 hours apart [too long?]**;
13. Effacement or dilation of the cervix, greater than a fingertip, accompanied by contractions, prior to 36 weeks gestation;
14. Measurements for fetal growth that are not within 2cm of the gestational age;
15. Second degree or greater lacerations of the birth canal;
16. An abnormal progression of labor;
17. An unengaged head at 7 centimeters dilation in active labor;
18. An abnormal presentation after 36 weeks;
19. Failure of the uterus to return to normal size in the current postpartum period; or
20. Persistent shortness of breath requiring more than 24 breaths per minute, or breathing which is difficult or painful.

B. A midwife shall obtain medical consultation to obtain a recommendation for treatment, referral, or transfer of care at the time any newborn demonstrates any of the following conditions:

1. Weight less than 2500 grams or 5 lbs., 8 oz.;

2. Congenital anomalies;
  3. An Apgar score less than 7 at 5 minutes;
  4. Persistent breathing at a rate of more than 60 breaths per minute;
  5. An irregular heartbeat;
  6. Persistent poor muscle tone;
  7. Less than 36 weeks gestation or greater than 42 weeks gestation by gestational exam;
- (Conflicts with 109 (C)(2))**
8. Yellowish-colored skin within 48 hours;
  9. Abnormal crying;
  10. Meconium staining of the skin;
  11. Lethargy, irritability, or poor feeding;
  12. Excessively pink coloring over the entire body;
  13. Failure to urinate or pass meconium in the first 24 hours of life;
  14. A hip examination which results in a clicking or incorrect angle;
  15. Skin rashes not commonly seen in the newborn; or
  16. Temperature persistently above 99.0° or below 97.6° F.

**~~R9-16-110.~~ R9-16-111. Emergency Measures**

- A.** A ~~licensed~~ midwife shall, before the arrival of emergency medical personnel, perform the following procedures only in an emergency situation in which the health and safety of the client or newborn are determined to be at ~~sufficient~~ risk:
1. Cardiopulmonary resuscitation of the client or newborn with a bag and mask;
  2. Administration of oxygen at no more than 8 liters per minute via mask for the client and 5 liters per minute for the newborn via neonatal mask;
  3. Midline episiotomy to expedite the delivery during fetal distress;
  4. Suturing of episiotomy or tearing of the perineum, to stop active bleeding, following administration of local anesthetic, contingent upon physician consultation or standing orders of physician;
  5. Release of shoulder dystocia by rotating the shoulders into one of the oblique diameters of the pelvis; and
  6. Manual exploration of the uterus for control of severe bleeding.
- B.** A ~~licensed~~ midwife may document the administration ~~administer a maximum dose of 20 units of~~ pitocin ~~intramuscularly, in 10-unit dosages each, 30 minutes apart,~~ to a client for the control of

postpartum hemorrhage; in the client's record. ~~contingent upon physician consultation or standing orders by a physician, and arrangements for immediate transport of the client to a hospital.~~

**~~R9-16-112.~~ Expired**

**~~R9-16-107.~~ R9-16-112. Recordkeeping and Report Requirements Client and Newborn Records**

- A. ~~Each midwife shall establish and maintain a record of the care provided and data gathered for each client.~~
- B. ~~Information in the client's record shall be released by the midwife only with the written consent of the client, legal guardian, or as otherwise provided by law.~~
- C. ~~If a client is a minor, informed consent shall be signed by the parent or legal guardian except as provided in A.R.S. § 44-132 and shall be filed in the client's record.~~
- D. ~~A midwife shall make records available to other health care providers engaged in the care and treatment of the client and upon request by the Department for periodic quality review.~~
- E. ~~A midwife shall maintain evidence of medical evaluation and physician visits in the client's record. Such evidence shall consist of either a report signed by the physician, a copy of the medical and physician notes, or other documentation received from the physician or medical provider.~~
- F. ~~A midwife shall enter a date for each entry in the prenatal record and the postpartum record. A date and time shall be recorded for each entry in the labor record. Each entry shall be initialed or signed by the midwife. If initials are used, the midwife shall sign on the same page.~~
- G. ~~Each licensed midwife shall submit a client summary report for each client to the Department. Such reports shall be submitted within 15 days after the close of each quarter on the form set forth as Exhibit E.~~
- H. ~~Each client's record shall contain the following information, as applicable:~~
  - 1. ~~Client identification sheet, including name, address, date of birth, sex, next of kin, spouse or other designated person, directions to the client's home, telephone number, and marital status;~~
  - 2. ~~Health history sheet including pre-existing conditions or surgeries, previous pregnancies, physical examination, nutritional status, and a written assessment of risk factors with an intervention plan when risk factors that require termination of the agreement are present;~~
  - 3. ~~Progress notes of all encounters with the midwife and other health care consultants, in chronological order, documenting any actions, guidance, and consultations, with copies if appropriate;~~

4. ~~Laboratory and diagnostic reports;~~
  5. ~~Written informed consent which is signed by the client.~~
- A. A midwife shall ensure that a record is established and maintained according to A.R.S. § 12-2297 for each:
1. Client, and
  2. Newborn delivered by the midwife from a client.
- B. A midwife shall ensure that a record for each client includes the following:
1. The client's full name, date of birth, and address;
  2. Names, addresses, telephone numbers of the client's spouse or other individuals designated by the client to be contacted in an emergency;
  3. Written informed consent signed by the client;
  4. The date the midwife began providing midwifery services to the client;
  5. The date the client is expected to deliver the newborn;
  6. The date the newborn was delivered, if applicable;
  7. An initial assessment of the client to:
    - a. Rule out that the client has a history of a condition or circumstance that would preclude care of the client by a midwife;
    - b. Determine the:
      - i. Number and outcome of previous pregnancies, and
      - ii. Number of previous medical or midwife visits the client has had during the current pregnancy;
  8. Progress noted documenting the midwifery services provided to the client;
  9. Laboratory and diagnostic reports;
  10. Medical consultations made about the client and the reason for each medical consultation;
  11. A description of any conditions or circumstances arising during the pregnancy that required the transfer of care;
  12. The name of the physician or hospital to which the care of the client was transferred, if applicable;
  13. Documentation of medications provided to the client;
  14. The outcome of the pregnancy;
  15. The date the midwife stopped providing midwifery services to the client, if applicable;  
and
  16. Instructions provided to the client before the midwife stopped providing midwifery services to the client.

C. A midwife shall ensure that a record for each newborn includes the following:

1. The full name, date of birth, and address of the newborn's mother;
2. The newborn's:
  - a. Date of birth,
  - b. Gender,
  - c. Weight at birth,
  - d. Length at birth, and
  - e. Apgar scores at one minute and five minutes after birth,
3. The newborn's estimated gestational age at birth;
4. Progress noted documenting the midwifery services provided to the newborn;
5. Laboratory and diagnostic reports;
6. Medical consultations made about the newborn and the reason for each medical consultation;
7. A description of any conditions or circumstances arising during or after the newborn's birth that required the transfer of care;
8. The name of the physician or hospital to which the care of the newborn was transferred, if applicable;
9. Documentation of medications provided to the newborn;
10. Documentation of newborn screening;
11. The date the midwife stopped providing midwifery services to the newborn, if applicable;  
and
16. Instructions provided to the client about the newborn before the midwife stopped providing midwifery services to the newborn.