STATE OF FLORIDA DEPARTMENT OF HEALTH
Council of Licensed Midwifery

LICENSED MIDWIFE ANNUAL REPORT

Please report data from January 1 through December 31 of each calendar year and submit to the Council within 30 days

SECTION 1: PRACTICE INFORMATION

1. **Licensed Midwife Name:** ____________________ **License Number:** ____________________

Name of Practice: (if applicable) ____________________ **Phone:** ____________________

Check all that is applicable to the above Midwife		
Solo Practice	**Multi Practice**	**No Data to report**

2. List All Other Licensed Midwives in the Multi Practice	License Number	Check if submitting additional individual annual report	Check if no additional data to report.
Name:			
Phone:			
Name:			
Phone:			
Name:			
Phone:			
Name:			
Phone:			
Name:			
Phone:			

SECTION II. CLIENT CARE SERVICES (include data for the report year only)

Section number			Total(s)
2	A	Total number of maternity clients accepted for care in the reporting period:	
	B	Total number of maternity clients accepted only for prenatal care:	
	C	Total number of Home deliveries:	
	D	Total number of Birthing Center deliveries:	
	E	Total number of maternity clients receiving Medicaid	
3	A	Number of mothers transferred antepartum (for medical reasons):	
	B	Number of mothers transferred intrapartum:	
	C	Number of mothers transferred postpartum: (medical reasons)	
	D	Number of Newborn transfers:	
4	A	Number of Stillborn (Midwife delivery)	
	B	Number of Neonatal Deaths (within 7 days of life)	
	C	Number of Maternal Deaths (please submit separate report)	

Additional information:

Newborn Birth weights - Please indicate how many babies delivered by midwife in each category

________ > or = to 9.9 lbs ________ 7.9 - 9.8 _________ 5.9 – 7.8 __________ < or = 5.8

SECTION III. TRANSFER INFORMATION

(3-A) ANTEPARTUM TRANSFER (Medical Reasons): (List each transfer separately. Do not list names.)

Date	Client Initials	Reason For Transfer	Gestational Age at Transfer	Delivery Outcome, if Known (NSVD, VAC, Forceps, C/S)

Total Number of Antepartum transfers (3-A) ______

(3-B) INTRAPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

				MOTHER	INFANT	
DATE	**Clients Initials**	**Number of Hours at home or Birth center**	**REASON FOR TRANSFER**	**Delivery Outcome NSVD, VAC, Forceps, C/S**	**BIRTH WEIGHT**	**APGARS**

Total Intrapartum Transfers (3-B) | |

(3-C) POSTPARTUM TRANSFERS: (List each transfer separately. Do not list names.)

Date	Client Initials	Reason For Transfer	# of Days in Hospital	Outcome/Condition on Discharge

Total Number of Postpartum Transfers (3-C) | |

(3-D) NEWBORN TRANSFERS: (List each transfer separately. Do not list names.)

Date	Baby's Initials	Reason For Transfer	Birth Weight	APGARS	# of Days in the Hospital	Outcome/Condition On Discharge

Total Newborn Transfers (3-D) | |

SECTION IV - DEATHS

(4-A) STILLBORN (midwife delivery)

Date	Baby's Initials	Cause of Death	Death Was:			Birth Weight	Gestational Age	Site of Delivery
			Before Labor	During Labor	During Delivery			

Total Number of Stillborn (4-A)	

(4-B) NEONATAL DEATH **(Deaths within seven days of life following midwife delivery of a live infant)**

Date	Baby's Initials	Cause of Death	Site of Death	Birth Weight	Age at death	Reported to The Medical Examiner?
					Total Number of Fetal/neonatal Deaths (4-B)	

(4-C) MATERNAL DEATH (PLEASE SUBMIT A SEPARATE REPORT)

Number of Reports Attached	
Total Number of Maternal Deaths (4-C)	

I have participated in giving information for the purpose of gathering statistics of Licensed Midwives in the State of Florida. The information I have given is accurate and true.

Print Name:	Signature	Date
Print Name:	**Signature**	**Date**
Print Name:	**Signature**	**Date**
Print Name:	**Signature**	**Date**
Print Name:	**Signature**	**Date**
Print Name:	**Signature**	**Date**

DOH-MQA 1052, 10/06

PLEASE MAIL ALL DOCUMENTS TO

Florida Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C06
Tallahassee, FL 32399-6330