Section:	**Professional Practice**	Section: IV	
Subject:	**Case Review, Consultation and Transfer of Care**	Issued: **April 2009** Revised: **April 2024** Next Review Date: **November 2025**	
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PREAMBLE

Midwives are primary care providers who are fully responsible for clinical decisions and the management of care within their scope of practice. In providing care, a midwife is responsible for recognizing conditions, which require case review, consultation, or transfer of care to another health care professional and to initiate this communication within an appropriate period of time.

The purpose of this policy is to describe the process for case review, consultation and transfer of care and to list the situations and/or circumstance where it is appropriate for this communication to take place. This policy also educates other health care providers, clients, and others involved, about the practice of midwifery and the parameters within which midwives practice.

This policy applies to all settings. **It is not intended to be exhaustive**; other circumstances may arise where the midwife or the client determines consultation or transfer of care is necessary.

CASE REVIEW

A *case review* refers to situations in which a midwife initiates a review of an individual case or provides information to a peer in order to plan care appropriately. The midwife shall document the case review and plan for care.

CONSULTATION

A *consultation* refers to the situation where a midwife requests the opinion of another appropriate health care provider. This is done in accordance with legislation and professional practice policies of the Saskatchewan College of Midwives. The midwife shall inform the client of the indication for consultation and discuss the options with the client as early as possible in the process of care. A midwife may also seek a consultation when the client requests another opinion.

In a subsequent pregnancy, clients who have had consultation for one or more indications *may not* require a repeat consultation if their condition remains optimized and stable since the previous pregnancy.

After consultation with a physician, primary care either:

a) Continues with the midwife,
b) Continues as shared care with midwife and consultant, or
c) Is transferred to a physician

The midwife shall discuss the consultant's recommendations with the client and ensure that the client understands which health professional will have responsibility for primary care. The most responsible provider must be clearly identified to all persons involved, including the client, and documented by the midwife and the consultant in the client's records.

TRANSFER OF CARE
When primary care is *transferred*, permanently or temporarily, from the midwife to a physician, the physician assumes full responsibility for subsequent decision-making with the client. The midwife may continue to provide supportive care within the midwifery scope of practice. Cooperation in the care of a client/newborn will be enhanced by mutual recognition of respective professional roles. Care may be transferred back to the midwife in situations where the client/newborn condition returns to within the normal scope of practice of the midwife.

ANTEPARTUM CARE

Indications for Consultation

- Medical, surgical, genetic, or hereditary conditions that may affect pregnancy, are exacerbated due to pregnancy or affect labour and birth
- Current primary outbreak of TORCH infection in pregnancy
- History of significant congenital anomalies that significantly impact pregnancy
- History of more than one preterm birth, or one preterm birth less than 34 weeks in a singleton pregnancy
- Previous uterine surgery other than one uncomplicated lower segment Caesarean section
- History of more than one second-trimester spontaneous abortion
- Previous stillbirth
- Uterine malformations and concerning uterine fibroids
- Concerning substance use
- Present severe mental health disorders or conditions
- History of three or more consecutive first trimester spontaneous abortions
- History or presence of cervical insufficiency
- Positive for any blood borne infections
- History of venous thrombosis
- Preterm pre-labour rupture of membranes at less than 36 weeks gestation
- Antepartum hemorrhage
- Rh isoimmunization or other positive antibody screen
- Persistent anemia unresponsive to therapy
- UTI unresponsive to therapy
- EFW less than 10th centile for gestational age
- Evidence of fetal growth restriction
- Suspected Fetal macrosomia
- Hypertensive disorders of pregnancy
- Intrauterine fetal demise
- Polyhydramnios
- Oligohydramnios
- Low lying placenta at equal to/greater than 36 weeks
- Fetal anomaly
- Twins [*]
- Non-cephalic presentation at equal to/greater than 36 weeks*
- Suspected or diagnosed placental abruption
- Abnormal fetal surveillance

[*] While many of these births may become transfers of care, twins and breech presentation are listed as indications for consultation to allow for collaboration between midwives and obstetrical consultants in deciding if a midwife may manage such a delivery, where a spontaneous birth is reasonably anticipated.

Indications for Transfer of Care

- Serious medical conditions which develop during pregnancy
- Missed or incomplete abortion requiring surgical intervention
- Molar pregnancy
- Extra-uterine pregnancy
- Hypertension requiring medication
- Placenta previa at equal to/greater than 32 weeks
- High Order Multiple Pregnancy
- Preterm pre-labour rupture of membranes less than 35 weeks gestation
- GDM requiring medication

DURING LABOUR AND BIRTH

Indications for Consultation

- Preterm labour less than 36 + 0 weeks gestation
- Abnormal vaginal bleeding
- Twins [*]
- Intrauterine fetal demise
- Breech presentation [*]
- Hypertensive disorders of pregnancy
- Obstructed labour
- Abnormal fetal heart rate pattern unresponsive to therapy
- Positive for any blood borne infections

Indications for Transfer of Care

- Preterm labour less than 35 weeks gestation
- Active genital herpes
- Uterine rupture
- Cord prolapse
- Malpresentation other than breech
- Hypertensive disorders of pregnancy requiring medication
- Repairs to fourth degree, urethral, clitoral and/or cervical tears

[*] While many of these pregnancies/births may become transfers of care, twins and breech presentation are listed as indications for consultation to allow for collaboration between midwives and obstetrical consultants in deciding if a midwife may manage such a delivery, where a spontaneous birth is reasonably anticipated.

POSTPARTUM

Indications for Consultation

- Retained placenta
- Postpartum haemorrhage unresponsive to treatment
- Severe pelvic floor dysfunction
- Haematoma not stabilizing
- Uterine infection
- Suspected venous thrombosis
- Hypertensive disorders of pregnancy or hypertension
- Postpartum mood disorders

Indications for Transfer of Care

- Thromboembolic disease

INFANT

Indications for Consultation

- Preterm baby less than 36 + 0 weeks gestation
- Abnormal transition of the neonate
- Infant below the 5th percentile for weight
- Abnormal findings on newborn assessments
- Infant born to a mother with blood borne infections or vertical transmission
- Infant born to a mother with current concerning substance use
- Failure of infant to regain birth weight with adequate feeding plan

Indications for Transfer of Care

- Infant below 35 + 0 weeks gestation
- Severe compromise of infant well-being on assessment

NOTE

Patients are autonomous and may refuse any form of consultation and/or transfer of care. Refer to SCM Policy "Client Request for Care Out of Scope".