SOUTH DAKOTA BOARD OF CERTIFIED PROFESSIONAL MIDWIVES
27705 460th Ave, Chancellor, SD 57015
Phone: 605-743-4451 Email: cpmsdlicense@gmail.com
https://doh.sd.gov/licensing-and-records/boards/certified-professional-midwives/

Maternal Transport Form

Date: _____

Client Name: _____ Client ID: _____ DOB: _____

Age: _____ G/P/A: _____ EDD:_____ Weeks Gest: _____ GBS+____ Rh- ____ Last B /P_____

ROM ____No ____Yes Date: _____ Time_____ Pregnancy Complications: _____

_____

Transport Information

Intrapartum: ____Early ____Active ____Transition Stage ____2 ____3 ____4

_____Emergent _____Non Emergent _____Stable _____Unstable

Mode of transport: ____Car ____Ambulance ____Helicopter

Reason for transport: ____(please see additional notes on the back)

___Pain Management ___Maternal Exhaustion ___Blood Pressure Hypertension ___Hypotension

___Malpresentation ___Breech ___Abnormal bleeding ___PPH ___Shock ___ Seizure ___Cardiac event

___Non Reassuring FHT ___Meconium ___Prolonged 2nd stage* ___Prolonged 3rd Stage *

___ Possible infection– fever ___Unstable Lie ___Placental Abruption ___Uncontrolled vomiting

___Extensive repair or 3rd/4th degree repair ___Preterm labor or rupture ___Uterine rupture ___Client request

___Other reason: _____

***2nd / 3rd Stage no progress—timeline**

Date: _____ Begin Time: 2nd _____ 3rd_____Transfer Time: _____

Information the receiving facility received from midwife: indicate all that apply

____Prenatal record ____Postpartum record ____Labor records ____Birth records ____Labs results ____U/S results

Time of call placed: _____ Receiving facility: _____

Receiving provider: _____

Midwife Name: _____ Midwife phone:_____

Signature:_____

Date of report: _____