Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

TO BE USED BY THE PERSON CALLING 911

Appendix A: Brief SBAR Script for Phone Call Initiating Transport by EMS

Instructions: Call 911. Read the script, inserting relevant information to initiate a transport.

Situation:

- This is (***name & credential or relationship***)
- Calling to transport a ***mother; baby; or mother & baby***
- From a planned ***home birth*** or ***freestanding birth center birth***
- Reason for Transport: ***ineffective labor; hemorrhage; newborn resuscitation; other (describe)***
- My call back number is _____
- The client's location is (street address) _____

Provide details of the location (consider in advance): how to find street, house, what floor, whether stretcher is needed or stairs are very narrow, where to find the women/baby if no one can come to the door, and any other pertinent information (such as loose dog in the house).

Background:

Briefly provide the most ***relevant clinical information*** to assist EMS with providing services, such as

- ☐ Client's name
- ☐ Significant prenatal history or labs
- ☐ Vital signs and fetal heart rate
- ☐ Dilation and station
- ☐ Meconium
- ☐ Previous cesarean
- ☐ Estimated blood loss
- ☐ Medications
- ☐ Time of birth
- ☐ Apgar score
- ☐ Newborn resuscitation (describe)
- ☐ Estimated gestational age
- ☐ Other information (describe)

Assessment:

Baby's current condition is ***(describe briefly, including urgency of transport)***
Mother's current condition is ***(describe briefly, including urgency of transport)***

Recommendation:

Requested course of action (***describe the interventions that have been initiated and what you want EMS providers to bring or provide for this woman and/or baby***), such as

- ☐ **Urgency of call**
- ☐ **Stretcher**
- ☐ **IV therapy**
- ☐ **Advanced airway management**
- ☐ **Resuscitation**
- ☐ **Other (describe):**

When client has been seen by a hospital-based provider, identify to EMS which hospital the provider is affiliated with and rationale for transporting to that hospital.

PLEASE NOTE: Once the above information has been relayed to Dispatch, ***birth providers may need to end call*** to allow for appropriate communication with appropriate hospital based provider(s)

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Appendix B: Brief SBAR Form for Recording Phone Call Initiating Transport by EMS Dispatch

Instructions: Complete this form while receiving communication to initiate a transport from a planned home or birth center birth.

Situation:

- ***Name & credential or relationship*** of caller: _____
- Transport of (please circle): ***mother*** ***baby*** ***mother & baby***
- From a planned (please circle) ***home birth*** ***freestanding birth center***
- Reason for Transport: ***ineffective labor; hemorrhage; newborn resuscitation; other (describe):*** _____
- The call back number is _____
- The client's location is (street address) _____

Details of the location: _____

_____

_____

Background:

Briefly provide the most ***relevant clinical information*** to assist EMS with providing services, such as

Client name: _____
Significant hx or labs: _____
Vital signs and fetal heart rate: _____
_____
Dilation and station: _____
Meconium: _____
Previous cesarean ☐ NO ☐ YES
Estimated blood loss: _____
Meds or Tx: _____

Time of birth: _____
Apgar score: 1 min_____ 5 min_____
Newborn resuscitation: ☐ Suctioning ☐ PPV
☐ Chest compressions ☐ Medications
Other: _____
Estimated gestational age: _____
Other information: _____
_____
_____

Assessment:

Baby's current condition: _____
Mother's current condition: _____

Recommendation:

Requested equipment, interventions, personnel and skill level

- ☐ **Stretcher**
- ☐ **IV therapy**
- ☐ **Advanced airway management**
- ☐ **Resuscitation**
- ☐ **Other (describe):** _____

Client has existing relationship with a provider at the following hospital: _____

PLEASE NOTE: *Once the above information has been relayed to Dispatch, birth providers may need to end the call to allow for appropriate communication with appropriate hospital based provider(s).*

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For Use by Any Party Using These Recommendations

Appendix H: Evaluation and Feedback on Tools Provided in the Maine CDC Best Practice Recommendations

The goal of these Recommendations is to facilitate safe perinatal transport by providing clinicians with tools to support communication and quality management. Your feedback is essential to maintaining the relevance of these Recommendations during the care and transport of newborns and women who are pregnant or postpartum.

1) Please identify which portions of the Recommendations you used during this transport?

- ☐ Transport Recommendations (for midwife or physician arranging transport)
- ☐ Best Practice Recommendations
  - ☐ Role of the Mother
  - ☐ Role of the Transferring Midwife or Physician
  - ☐ Role of the Emergency Medical Service Provider
  - ☐ Role of the Receiving Registered Nurse
  - ☐ Role of the Receiving Obstetrical or Pediatric Care Physician or Practitioner
- ☐ Brief SBAR Script for Phone Call initiating Transport
  - ☐ By EMS
  - ☐ To Hospital
- ☐ Brief SBAR Form for Recording Phone Call
  - ☐ Initiating Transport by EMS Dispatch
  - ☐ To Hospital regarding Transport
- ☐ Maternal/Neonatal Transport Form from Home or Freestanding Birth Center
- ☐ Definitions
- ☐ Professional Competence Review Process

2) The Recommendations were clear and understandable. ☐ Agree ☐ Neutral ☐ Disagree

3) The tools enhanced communication during transport ☐ Agree ☐ Neutral ☐ Disagree

Do you recommend any changes to the Recommendations? (please specify) _____

_____

_____

Comments: _____

_____

You may provide your name and contact information so that we may follow-up on recommendations or comments

Name:_____ **Contact Info:**_____

Please submit completed evaluations to the Maine CDC

Attention: Toni.G.Wall@maine.gov or Valerie.j.Ricker@maine.gov FAX 207-287-5355

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For Use by Families Who Experience a Maternal or Newborn Transport from a Planned Home or Freestanding Birth Center Birth

Appendix I: Evaluation and Feedback about Transport Process

The goal of the Recommendations is to facilitate safe perinatal transport. The opportunity for personal evaluation and feedback of the ***transport process*** is essential to identify ways to improve the transport experience for families involved in the care and transport of newborns and women who are pregnant or postpartum. Completion of this form is optional.

Please tell us about you	**Circle One**		
Please tell us who you are:	Parent	Other Family Member	Family Friend
Please tell us who was transported:	Mother	Baby	Mother & Baby
Please tell us the planned birth location:	Home Birth	Birth Center Birth	Hospital
Please tell us about your experience	**Agree**	**Neutral**	**Disagree**
I was treated respectfully			
The information I was provided was clear and understandable			
Communication between professionals was clear and relevant to ensuring a safe and effective transport			
I felt supported during the transport process			
I felt supported during after the transport process			

What part of the transport process went well? (please describe) _____

_____

What part of the transport process could be improved? (please describe) _____

_____

Comments: _____

_____

You may provide your name and contact information for follow-up

Name:_____ **Contact Info:**_____

Please submit completed evaluations to the Maine CDC

Attention: Toni.G.Wall@maine.gov or Valerie.j.Ricker@maine.gov FAX 207-287-5355