



Midwives Alliance of Hawaii

Registry of Midwives

Peer Review Summary

Date: _____

Name of Midwife: _____

Mailing Address: _____

Email Address: _____ Phone number: _____

Dates Reporting: _____, 20____ to _____, 20____.

Total number of prenatal clients: _____ Number of NSVD completed: _____

Total number of SABs: _____ Total number of ITOPs: _____

Total number of clients referred out during the following time periods:

a. Antepartum: _____ b. Intrapartum: _____ c. Postpartum: _____

Total number of clients requiring consultation or referral during the following time periods:

a. Antepartum: _____ b. Intrapartum: _____ c. Postpartum: _____

Total number of clients that left your practice for reasons other than being risked out: _____

Total number of transports during intrapartum: a. Maternal: _____ b. Neonatal: _____

Total number of transports during postpartum: a. Maternal: _____ b. Neonatal: _____

Total number of other outcomes: a. IUFD (≥ 24 wks): _____ b. Still birth: _____

c. Neonatal death: _____ d. Other (specify): _____

*IUFD is a baby (≥ 24 wks) with no signs of life in utero. Still birth is a baby delivered (≥ 24 wks) with no signs of life. Neonatal death is the death of a baby in the first 28 days of life (0-27 days).



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Peer Review Confirmation Statement

This is to confirm that _____ has participated in Midwives Alliance of Hawaii's Peer Review process on the _____ day of _____, in the year _____.

Number of midwives present _____

Number of cases presented _____

Number of hours spent during process _____

Signed,

MAH Representative Signature

Date

Printed Name