Te Whatu Ora
Health New Zealand

Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)

Aratohu Aratohu Kimi Āwhina ki Te Ratonga Whakawhānau Pēpi, Ratonga Rata (Ngā Aratohu Tuku Atu)

March 2023

These guidelines are to be used in conjunction with the Primary Maternity Services Notice 2021 (www.health.govt.nz/publication/primary-maternity-services-notice-2021) and relevant funded maternity service specifications (https://nsfl.health.govt.nz/service-specifications/current-service-specifications/maternity-service-specifications).

Te Kāwanatanga o Aotearoa
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Glossary of terms used in the guidelines

Community maternity facility	A community-based birthing unit, usually staffed by midwives. Community maternity facilities provide access for women/people assessed as being at low risk of complications for labour and birth care. Such facilities do not provide specialist services.
Consultation	The process by which, in communication with the woman/person, a referrer seeks an assessment, opinion and advice about the woman/person and/or the baby from a specialist or secondary/tertiary hospital team, by way of a referral. A consultation may or may not result in transfer of clinical responsibility for care. Consultations may involve the woman/person and/or the baby being seen by the specialist; however, a discussion between health practitioners is often appropriate on its own. Consultation can take place in person, by telephone, videoconference, email or by other means as appropriate in the situation.
Emergency transport	The physical transport of a woman/person and/or baby by air or road ambulance in an emergency.
Family planning practitioner	A health practitioner who is registered with the Medical Council of New Zealand (established by the Health Practitioners Competence Assurance Act 2003) in the vocational scope of practice of family planning and reproductive health and who holds an annual practising certificate.
General practitioner (GP)	A health practitioner who is registered with the Medical Council of New Zealand (established by the Health Practitioners Competence Assurance Act 2003) in the vocational scope of general practice and holds a current annual practising certificate.[1]
Health practitioner	Trained medical professionals, encompassing those who may provide health care at the time an offer of consultation or transfer of clinical responsibility for care becomes relevant.

[1] In some areas, certain specialist obstetric procedures or maternity services may also be delivered by a rural generalist (obstetrics). A rural generalist (obstetrics) is credentialled by the institution they work in.

Hospital team	The team that includes midwives, obstetricians, neonatologists, anaesthetists and others. These secondary or tertiary maternity team members work collaboratively together, and with the LMC, to achieve the best health outcome for the woman/person and their baby.
Lead maternity carer (LMC)	A person who is a midwife, obstetrician or a GP with a Diploma in Obstetrics, a Postgraduate Diploma in Obstetrics and Medical Gynaecology or equivalent (as determined by the Royal New Zealand College of General Practitioners) and who is either a maternity care provider or an employee of or contractor to a maternity care provider and has been selected by the woman/person to be their LMC.
Maternity care provider	All health practitioners who provide maternity care at the time an offer of consultation or transfer of clinical responsibility for care becomes relevant. For example, a maternity care provider may be a community midwife, obstetrician, GP or family planning practitioner.
Primary health care provider	A health care provider who works in the community and is not a specialist for the purposes of these guidelines. This provider may be another midwife, a GP or a nurse practitioner. Allied health providers include physiotherapists and, lactation consultants. Other relevant services include kaupapa Māori services, smoking cessation services, drug and alcohol services, nutrition services or mental health services.
Referral	The process by which one health practitioner (usually the LMC) seeks consultations with or transfers clinical responsibility for care of a condition affecting the woman/person and/or their baby to another appropriate health practitioner.
Secondary maternity service	A secondary maternity service that provides the services specified in the service specification for secondary and tertiary maternity services available from the Nationwide Service Framework Library.
Specialist	A medical practitioner who is registered with a vocational scope of practice in the register of medical practitioners maintained by the Medical Council of New Zealand and holds a current annual practicing certificate. For the purposes of these guidelines, this definition excludes GPs because GPs are covered by the primary referral process.

Tertiary maternity service	A tertiary maternity service that provides the services specified in the service specifications for secondary and tertiary maternity services available from the Nationwide Service Framework Library.
Three-way conversation	A single face-to-face phone or video communication event that simultaneously involves a woman/person, their LMC midwife/referrer and a specialist that is supported by documented care plans and/or written communications.
Transfer of clinical responsibility for care	The transfer of clinical responsibility for care from the LMC to a specialist. Responsibility for care may be transferred back to the LMC if/when clinically appropriate. In obstetric emergencies, transfer of clinical responsibility will be to the most appropriate available health practitioner.

Introduction

Purpose

The *Guidelines for Consultation with Obstetric and Related Medical Services (the Referral Guidelines)* aim to:

- set out the care pathways that women/people can expect when engaging with maternity care services (depending on their health needs)
- improve safety in and the quality of maternity care services
- improve the consistency of consultation, transfer of clinical responsibility for care and transport processes
- reassure women/people, their whānau and health practitioners if a primary health care or specialist consultation or a transfer of clinical responsibility for care is required
- promote and support coordination of care across maternity care providers.

The *Referral Guidelines* are based on best practice and are informed by available evidence, expert opinion and maternity service delivery in Aotearoa New Zealand. They sit alongside other relevant clinical guidelines and should be read in conjunction with ***Ngā Paerewa Health and Disability Services Standard NZS 8134:2021*** (*Ngā Paerewa*) and the corresponding sector guidance for birthing units and district health board (DHB) in-patient / private hospital services. The Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 legislation is also relevant. Together, these documents provide a suite of information about best-practice maternity service provision.

The *Referral Guidelines* relate to medical care. We recognise that socioeconomic determinants also have an impact on health, but these sit beyond the *Referral Guidelines'* scope.

Meaning of 'LMC' and 'health practitioner' in these guidelines

The terms 'LMC' and 'health practitioner' are used throughout the *Referral Guidelines*.

The Primary Maternity Services Notice 2021 defines a lead maternity carer (LMC) as:

- a midwife, an obstetrician or a general practitioner (GP) with a Diploma in Obstetrics, a Postgraduate Diploma in Obstetrics and Medical Gynaecology or equivalent (as determined by the Royal New Zealand College of General Practitioners); and

- either a maternity care provider in their own right or a practitioner who is an employee of or contractor to a maternity care provider; and
- who has been selected by the woman/person to provide her lead maternity care.

The LMC is based in the community and is responsible for coordinating the woman/person's maternity and postnatal care, or a baby's postnatal care once the care recipient is registered with them. Not every woman/person will have a named LMC due to specific care requirements or circumstances. Women/people may receive midwifery care from an employed case-loading midwife or hospital-based midwifery team. These midwives along with other health practitioners (such as GPs, nurse practitioners or family planning practitioners) may also need to refer the woman/person for specialist services.

For the purposes of the *Referral Guidelines*, the term 'health practitioner' encompasses those who may provide health care at the time an offer of consultation or transfer of clinical responsibility for care becomes relevant.

If the woman/person has an LMC (including a named community midwife/midwifery team), that LMC should make the referral. This supports clarity of responsibility and ongoing care provision and enables the LMC to remain as the main point of contact for communications and planning. Any other health practitioner providing care for a pregnant or postnatal woman/person or their baby who considers that a referral is warranted should contact the LMC in the first instance to discuss the case and their concerns.

If the woman/person does not yet have an LMC, the health practitioner providing care should prioritise linking the woman/person with an LMC before referring them to specialist services (where the referral is for a non-urgent issue). Health practitioners are expected to make a referral in acute or time-critical situations where the woman/person has not yet registered for maternity care, or when they have stated that they were unable to contact their usual carer or the hospital. The LMC should be notified that such a referral has occurred.

Users of the *Referral Guidelines*

The *Referral Guidelines* are relevant to all health practitioners involved in caring for pregnant and birthing women/people, postnatal women/people and their babies in Aotearoa New Zealand. Regardless of their place of work, health practitioners should use the *Referral Guidelines* to support their clinical judgement, knowledge and expertise and provide for a timely, consistent and effective approach to the woman/person's maternity care.

Women/people and their whānau can use the Referral Guidelines to understand how they might access health services during pregnancy, birth and in the postpartum period.

Te Tiriti o Waitangi

Health practitioners can demonstrate that they are giving effect to Te Tiriti by practically applying the principles as articulated by the courts and the Waitangi Tribunal.[2] Applying the principles to maternity service delivery is an obligation, enabling Māori to express their mana[3] motuhake and ensures they receive high-quality, culturally safe care and achieve equitable health outcomes. Applying the principles of Te Tiriti is a mandated obligation of maternity services and health practitioners.

The principles of Te Tiriti provide the framework for maternity providers and health practitioners providing maternity services to Māori. *Ngā Paerewa* and, in particular, **1.1 Pae ora healthy futures** supports the understanding of how these principles should be applied to maternity services.

The Waitangi Tribunal concluded that persistent health inequities that Māori experience were the consequence of the failure to apply the principles of Te Tiriti at structural, organisational and health practitioner levels of the health and disability sector. Giving effect to Te Tiriti requires health practitioners to know the principles of Te Tiriti and to capably apply these in partnership with Māori in their day-to-day maternity clinical practice.

For the health and disability sector, the Ministry of Health articulates the **principles of Te Tiriti** as follows.

- **Tino rangatiratanga**: Health practitioners support the right of Māori to receive effective maternity care, conceptualising the decisions of the woman/person as a continuation of a much older, Māori collective-endorsed practice of sovereignty of one's own health and wellbeing, as well as that of one's whānau.
- **Equity**: Health practitioners can contribute to equitable maternity health outcomes for Māori by ensuring that, at a minimum, maternity outcomes for Māori match those for other Aotearoa New Zealand ethnic groups. Equitable maternity outcomes will be achieved when health practitioners implement the Referral Guidelines recommendations in ways that give effect to the principles of Te Tiriti, relevant professional competencies and Ngā Paerewa.
- **Active protection**: Health practitioners share evidence-based information about maternity outcomes so that Māori can make decisions and prepare themselves to uphold their tikanga or cultural practice (for example, karakia, rongoā, support people).

[2] In: Waitangi Tribunal. 2019. Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Wellington: Waitangi Tribunal. URL: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf (accessed 2 February 2022).

[3] See Ministry of Health's Te Tiriti o Waitangi Framework for the Ministry's four goals, each expressed in terms of mana. URL: https://www.health.govt.nz/system/files/documents/pages/whakamaua-tiriti-o-waitangi-framework-a3-aug20.pdf (accessed 2 February 2022).

Health practitioners actively support Māori on the decision making continuum by providing quality evidence based information, free from bias and judgement.

- **Options**: Health practitioners ensure Māori have maternity care that enables them to uphold their tikanga or cultural practice regardless of where the birth takes place. Processes must complement a Māori person's mana or inherent authority and dignity, support their tikanga or cultural practice and be culturally safe as defined by Māori.
- **Partnership**: Health practitioners work in partnership with Māori, including a person's whānau if the person requests it. A partnered approach to the process and decision-making ensures Māori can enact their rangatiratanga or self-determine their futures while exercising mana motuhake or authority over their bodies and reproductive health.

Guiding principles

The woman/person, their baby and their whānau (as defined by the woman/person) are at the centre of all discussions and decisions.

- The woman/person should have continuity of maternity care through a single point of contact, regardless of how that care is provided (for example, through a community-based approach or through a secondary or tertiary maternity service).
- Health practitioners should take a holistic view of the woman/person's circumstances, clinical and social history, and overall wellbeing (considering models of holistic wellbeing such as Te Whare Tapa Whā[4]) and apply clinical judgement to individual or combinations of factors when determining the need for referral or a transfer of clinical responsibility for care.
- Under right 7 of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, the woman/person (or parents) has the right to make an informed decision and give informed consent on all aspects of their care, including the right to decline care and to decline referral for consultation or a transfer of clinical responsibility for care. To enable 'informed decision', right 6 of the Code requires that the woman/person (or parents) receive full, accurate, unbiased information about the options, the risks, side effects, benefits and costs of each option and the likely outcomes of the decisions.
- Health practitioners should be aware that different cultures conceptualise anatomy, pregnancy, birth and the postpartum period in different ways, and the practitioners should adapt their language and approach accordingly. Bias and stigma may be associated with certain health conditions. Health practitioners should recognise the importance of reflection and self-evaluation to ensure they communicate with women/people/parents in ways that do not perpetuate negative attitudes, behavioural bias or coercion.
- Health practitioners are responsible for clinical decisions and actions and for acting within their competency and scope of practice and within system constraints.
- Communication between all health practitioners involved with the woman/person's or their baby's care will include the woman/person or parents and will be open, clear, timely and appropriately documented in health records.
- Transfer of clinical responsibility for care is a negotiated process involving the woman/person (or parents), the LMC and the health practitioner to whom clinical responsibility is to be transferred.

[4] For more information, see the webpage Māori health models – Te Whare Tapa Whā on the Ministry of Health website at URL: www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha

- All health practitioners involved are responsible for appropriately documenting decisions in the woman/person or baby's records, including any variation from the Referral Guidelines or other guidelines and the circumstances of any such variation. Documentation of all steps by all health practitioners involved is particularly necessary where clinical responsibility for care transfers from one health practitioner to another.
- Women/people and their babies should have access to an evidence-based and consistently high standard of care, regardless of where they live. The approach to referral for consultation, transfer of clinical responsibility for care and emergency transport should be nationally consistent with equitable access to services regardless of location, with some allowance for local needs and conditions. The ways that this standard of care is achieved may differ depending on local situations.

Categories of referral

Table 1: Categories of referral

Referral category	Consequent action
Primary	The LMC discusses with the woman/person (or parents) that a consultation may be warranted with a GP, midwife, nurse practitioner or other relevant primary or allied health provider (for example, kaupapa Māori service, Whānau Ora service, physiotherapy, lactation consultancy, smoking cessation service, drug and alcohol service, mental health service, etc.) because the pregnancy, labour, birth or puerperium (or the baby) is, or may be, affected by a condition that would be better managed by, or in conjunction with, another primary health care provider. Where a referral occurs, there is a professional responsibility to maintain communication, collaboration and documentation and to inform the LMC in writing of the outcome of the referral. Where there is no LMC, communication must include the referrer. This should include discussion of any ongoing management of the condition by the primary health care provider. Clinical responsibility for the woman/person's maternity care remains with the LMC. Referring a person on to a primary health care, allied health or kaupapa Māori service provider may lead to a further referral for consultation or a transfer of clinical responsibility for care. In this event, the provider must notify the LMC (or the referrer if no LMC) of any referral or transfer.
Consultation	The LMC must recommend to the woman/person (or parents in the case of the baby) that a consultation with a specialist is warranted because the pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. Where a consultation occurs, the decision regarding ongoing care and advice on management and any recommendation to subsequently transfer care must involve a three-way conversation between the woman/person, the specialist and the LMC. Where there is no LMC, any communications must include the referrer. This includes discussing any need for and timing of specialist review. Advice on the timing of the referral is provided for some of

	the listed conditions, but timing is generally indicated by the severity of the condition, the experience and scope of practice of the referrer, the availability of services and the woman/person's ability to access those services. A specialist will not automatically assume responsibility for ongoing care following a consultation. This responsibility will vary with the clinical situation and the wishes of the woman/person. A consultation with a specialist may result in a transfer of clinical responsibility for care. In this event, the specialist formally notifies the LMC and documents it in the woman/person's or their baby's records. If the woman/person is not registered with an LMC, the specialist must notify the referrer and document the transfer in the woman/person's or the baby's records.
Transfer	The LMC must recommend to the woman/person (or parents in the case of the baby) that the responsibility for care be transferred to a specialist because the pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The decision regarding ongoing clinical roles/responsibilities must involve a three-way conversation between the woman/person, the specialist and the LMC. Where there is no LMC, all communications must include the referrer. The specialist will assume ongoing clinical responsibility, and the role of the LMC from that point on will be agreed between those involved. This should include a discussion about timing for transferring clinical responsibility back to the LMC when the condition improves, which must involve the woman/person, the relevant specialist and the LMC. Where there is no LMC, the discussion must include the referrer. Decisions on transferring clinical responsibility for care should be documented in the woman/person's and/or their baby's records.
Emergency	An emergency necessitates the immediate transfer of clinical responsibility for care to the most appropriate health practitioner available. Responding to an emergency may include providing emergency transport by road or air to a secondary or tertiary maternity facility that is able to provide the necessary level of care (see process map 5: Emergency transport).

	In such circumstances, the clinical roles and responsibilities are dictated by the immediate needs of the woman/person and/or their baby and the skills and capabilities of the available health practitioners, including those involved in providing emergency transport if it is required. The LMC is likely to have an ongoing role throughout the emergency, with the nature of that role depending on the other health practitioners present.

Process for referral for consultation and/or transfer of clinical responsibility for care

The following process maps set out referral processes.

This guidance is for all health practitioners involved in a woman/person's or the baby's care during pregnancy and birth and during the postpartum period. It includes health practitioners involved in referral for consultation, transfer of clinical responsibility for care and emergency situations.

There is guidance on what to do if a woman/person (or the parents) declines any of these options.

The aim is to provide a consistent level of service, delivered according to local needs and conditions.

Timing

The decision to refer and the timeliness of being seen will depend on factors such as:

- the severity of the condition(s)
- the referrer's experience and scope of practice
- the wishes/preferences of the woman/person and/or their whānau
- the maternity facility or service where the care is provided
- the availability of services or health practitioners
- woman/person's or the baby's access to services.

All health practitioners are responsible for their clinical decisions, including the timing of referral.

In light of the above factors, these guidelines do not generally include timing recommendations for each condition. However, there are some conditions for which a

specific timing for referral for consultation or transfer of clinical responsibility for care is recommended to ensure that certain actions or treatments and management decisions occur appropriately.

There may be situations when services required for a woman/person (or baby) are not available in the area or are not available in a timely manner. In this situation, the referrer should make the referral and document it in the woman/person's and/or the baby's records. Where appropriate, the referrer should contact the service receiving the referral and advise it of the situation. The referrer should, where necessary, discuss other options for care with the woman/person or parents. Where a referral is not accepted, the service receiving the referral should provide advice to the referrer about a documented management plan and ensure that this is included in the woman/person's or the baby's records.

Process maps

The process maps that follow show the critical steps that referrers should take in response to the different categories of referral (primary, consultation, transfer and emergency – see table 1: Categories of referral above).

Flexibility is important if the *Referral Guidelines* are to be used effectively. Local situations vary in geography, demographics, workload and workforce. Situations can change rapidly, especially in emergencies. The process maps should provide a framework for, but not override, local protocols that have been developed involving a multidisciplinary approach to achieve the same outcome in ways that work for local needs and circumstances.

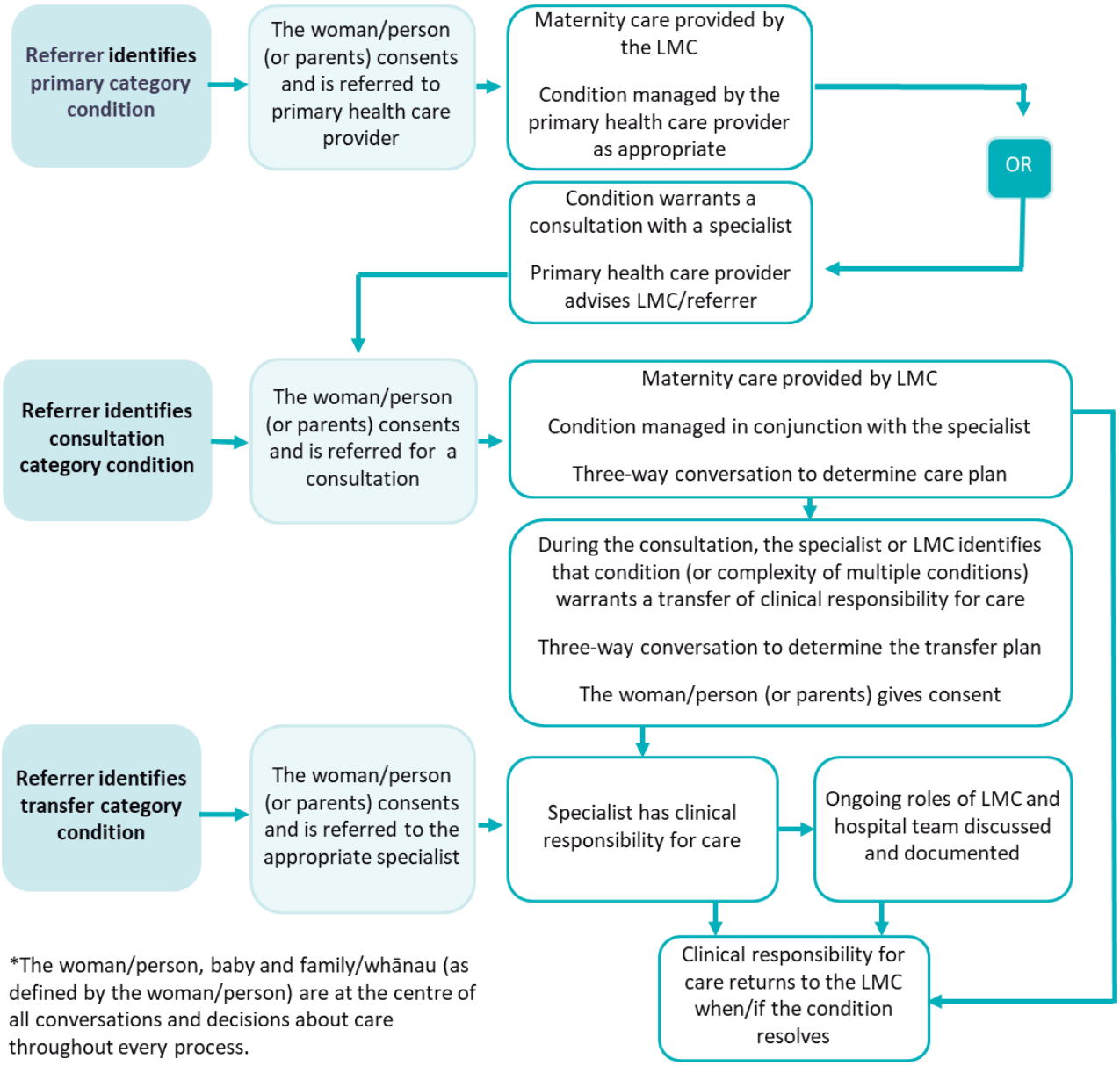
Where clinical responsibility for care is transferred to a specialist, the LMC can continue to provide care within their scope of practice and competence and with the support of the specialist team and with the woman/person's (or parents') agreement.

The process maps are a continuum: a referral may result in a specialist consultation or a transfer of clinical responsibility for care if that is found to be necessary.

Each of the six process maps must be used with reference to the process notes.

Referrers should not rely on the process maps alone for guidance.

Process maps as a continuum



Process for referral to a primary health care, allied health or kaupapa Māori service

If a health practitioner finds that a woman/person (or baby) has a condition in the primary referral category, they should discuss with the woman/person (or parents) the fact that a consultation may be warranted with a primary health care, allied health or other service (for example, another midwife, GP, nurse practitioner, physiotherapist, lactation consultant

or kaupapa Māori, Whānau Ora, nutrition, smoking cessation, drug and alcohol, or mental health service).

There are many health-related conditions that can affect pregnant women/people and babies. The list of referral criteria does not cover all of them by any means but instead focuses on those that are relevant during pregnancy and in the earliest days postpartum. It may be appropriate for a health practitioner to recommend that a woman/person (or parents) consult a GP, midwife, nurse practitioner or other allied health or kaupapa Māori service regarding a condition that is not included in the referral criteria list.

Most women/people in Aotearoa New Zealand are enrolled with a general practice or primary health care clinic, which holds their medical records and provides care for ongoing medical needs. Many women/people will attend their general practice to confirm their pregnancy and receive initial advice.

General practice and maternity care are funded separately. Maternity care provided by a midwife, a GP, rural generalist (obstetrics) or a hospital team is free to all eligible women/people. If a woman/person chooses a private specialist obstetrician, they may need to pay a charge in addition to the government subsidy. General practice care is partially subsidised and may incur a part charge when provided to pregnant women/people. Each practice sets its own charges. The referrer must advise the woman/person that there could be a charge for non-maternity related primary or allied health care.

Roles and responsibilities

When a woman/person or baby is referred to a primary health care, allied health or kaupapa Māori service, the new health care provider may provide advice or ongoing management for the condition while the referring LMC retains the clinical responsibility for maternity care. The referral may result in a recommendation that the condition requires the offer of a referral for specialist consultation or a transfer of clinical responsibility for care. This is covered by the consultation or transfer process maps. In all cases, there is a professional responsibility to maintain communication, collaboration and documentation and to inform the LMC/referrer, in writing, of the outcome of the referral. This information should be included in the woman/person’s or the baby’s records.

Communication

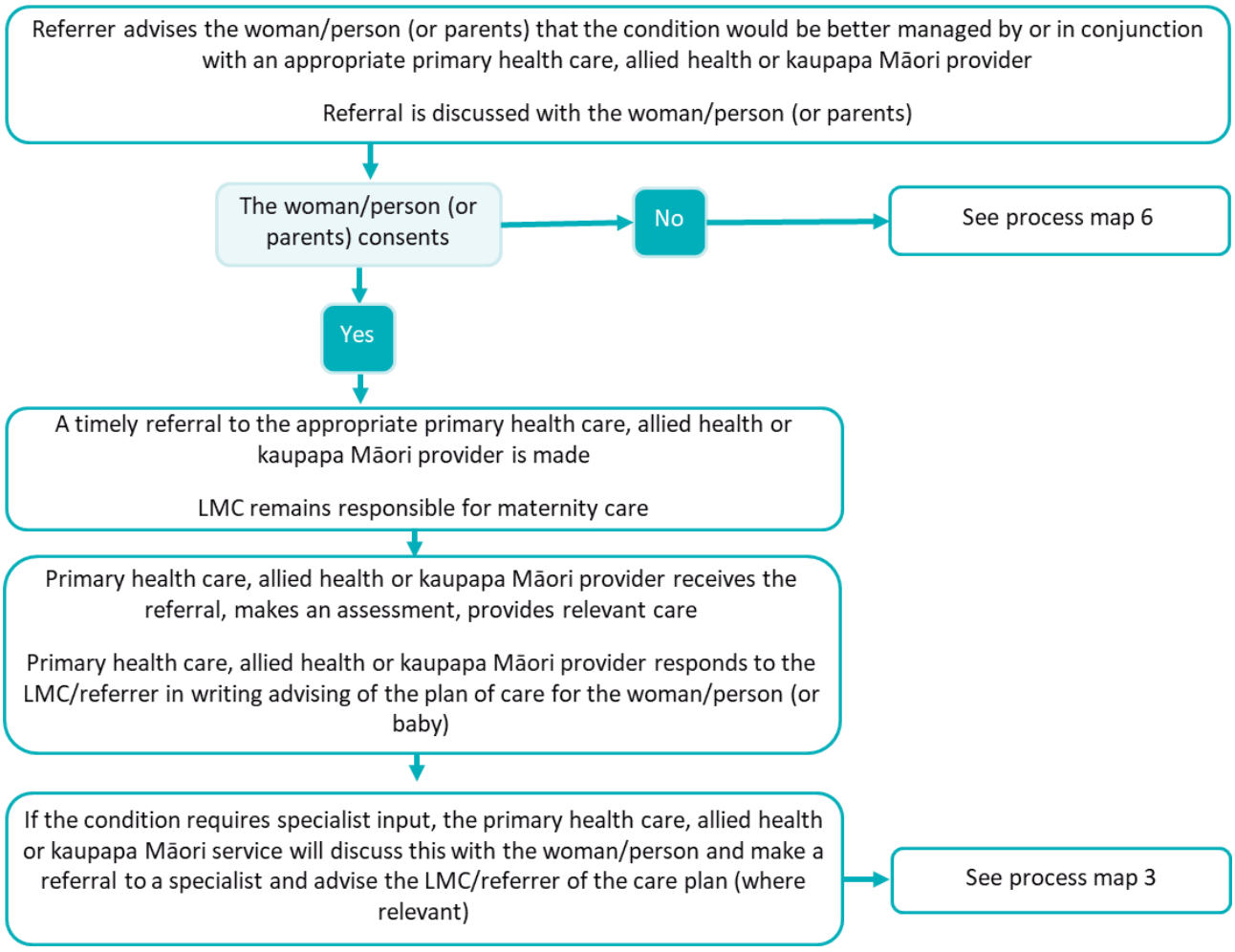
Referral to a primary health care, allied health or kaupapa Māori service requires the referrer to provide adequate information to that provider, including any relevant clinical notes, test results, histories, etc. It also requires the new health care provider to notify the LMC/referrer of:

- any subsequent referrals

- any recommendations for the LMC's ongoing management of the woman/person and/or the baby
- changes in medication or management of the condition itself
- test results
- any other relevant information.

All communication and information sharing must be timely, appropriate and complete.

Process map 1: Referral to a primary health care, allied health or kaupapa Māori service



*The woman/person, baby and family/whānau (as defined by the woman/person) are at the centre of all conversations and decisions about care throughout every process.

Process for referral to a specialist for consultation

For the conditions listed in the consultation referral category, the referrer must recommend the woman/person (or parents) consult with a specialist.

Consultation can be in the form of a discussion between the referrer and the specialist on the phone or via videoconference or email. The consultation may result in the specialist seeing the woman/person (or baby) in person. The specialist consultation may be done by an individual health practitioner and may include review by a secondary services team. If they are not the referrer, the LMC should be consulted on the need for referral. The consultation should discuss ongoing responsibilities between the LMC and the specialist.

If a woman/person sees a GP before an LMC is chosen and the GP identifies a condition that requires a specialist consultation, the GP can refer as per process map 2. Once the woman/person has chosen an LMC, the GP should provide the LMC with all the relevant information.

The specialist to whom the woman/person (or baby) is referred may be an obstetrician, gynaecologist, radiologist, anaesthetist, physician, psychiatrist, surgeon, paediatrician or a service such as genetic services.

Roles and responsibilities

At the time of the consultation, the clinical responsibility for care remains with the LMC. The specialist should advise the LMC/referrer of recommended monitoring and provide a documented care plan that has been agreed between the woman/person (or parents), the specialist and the LMC. The specialist may become responsible for managing the specific condition if that is appropriate and warranted, and if the woman/person (or parents) agrees.

If the condition increases in severity, or if there are multiple conditions warranting consultation with a specialist, the LMC/referrer may request that the clinical responsibility for care be transferred to the specialist.

Communication

This process assumes that the decisions about a woman/person's (or baby's) care are based on a three-way conversation between the woman/person or parents, the LMC and the specialist. Where there is no LMC, communication must include the referrer.

The referrer should provide the specialist with access to all necessary clinical notes and information at referral. The specialist is responsible for informing the LMC of decisions,

recommendations and advice as part of the documented plan of care following the consultation. Where there is no LMC, communication must include the referrer.

Meeting local conditions

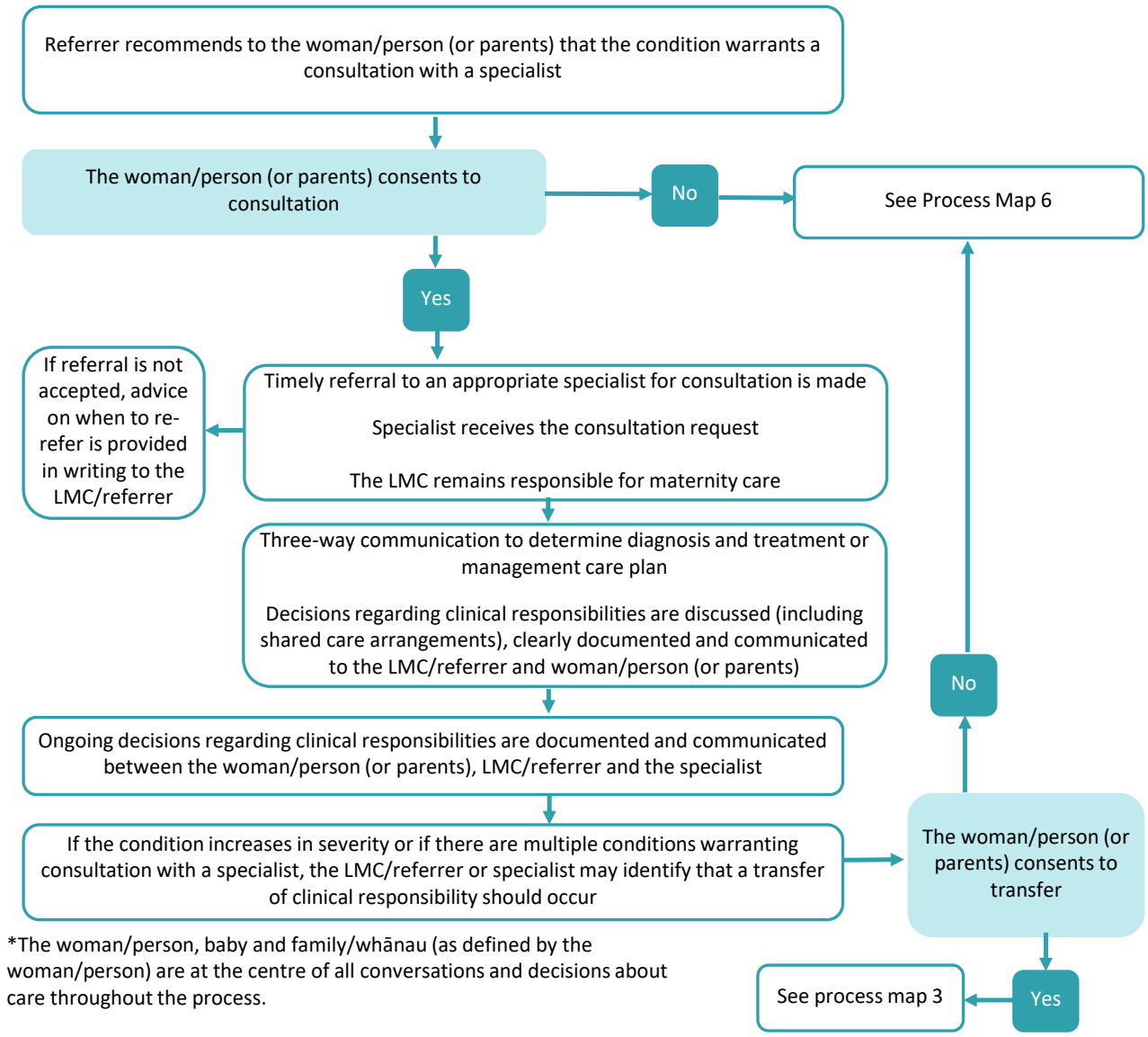
The referral process will need to take account of:

- capacity of local/regional secondary health care services to see women/people (or babies) in a timely manner
- access to the required specialist services in the area (for example, genetic services are not readily available in all areas of Aotearoa New Zealand)
- distances, time and cost for the woman/person to reach a hospital if an in-person consultation with a hospital-based specialist is needed.

These factors should not influence whether a referral to a specialist for consultation is made but may be pertinent in deciding whether service capacity can meet a specific clinical need.

The steps in process map 2 should be reflected in local processes or protocols.

Process map 2: Referral to a specialist for consultation



Process for transfer of clinical responsibility for care

Roles and responsibilities

If a condition increases in severity or there are multiple conditions warranting consultation with a specialist, the LMC/referrer may request that the clinical responsibility for care be transferred to the specialist.

For the conditions listed in the transfer referral category, the referrer must recommend transfer of clinical responsibility for care to a specialist. Once clinical responsibility for care is transferred, clinical decisions and decisions on the roles and responsibilities of all other

health practitioners involved with the woman/person's (or baby's) care rest with the specialist, considering the needs and wishes of the woman/person (or parents). The LMC retains clinical responsibility for care until the transfer has been completed.

Continuity of care should be preserved wherever possible, and there is potential for LMCs to retain a role in providing care for the woman/person (or baby), especially where the LMC is a midwife. For example, a woman/person who is pregnant with twins requires specialist oversight but can continue to receive midwifery care from an LMC midwife. The specialist has clinical responsibility and a clear, written care plan including roles and responsibilities is documented in the woman/person's or the baby's records.

An LMC may decline ongoing involvement with a woman/person's (or baby's) care if the clinical situation moves outside their scope of practice or experience or unreasonably impacts on their workload. The LMC must ensure that all relevant care is transferred appropriately.

Communication

It is critical to document the point at which responsibility for coordination and provision of maternity or neonatal care is formally transferred to the specialist. This requires:

- a three-way conversation between the woman/person (or parents), the LMC and the specialist to determine that the transfer of clinical responsibility for care is appropriate and acceptable (where there is no LMC, communication must include the referrer)
- the LMC to provide the specialist with access to all relevant information, including any relevant clinical notes, test results (including through shared platforms) and histories
- a discussion and documented decision in the woman/person's or baby's records about the nature of the ongoing role of the LMC or whether all care is transferred to the specialist and the hospital midwifery team.

Transfer of clinical responsibility for care requires timely and full communication between the LMC and the specialist. All other health practitioners directly involved in the referral process (for example, the GP or other primary health care, allied health or kaupapa Māori services) should be informed of the decisions made.

Meeting local conditions

The process will need to take account of:

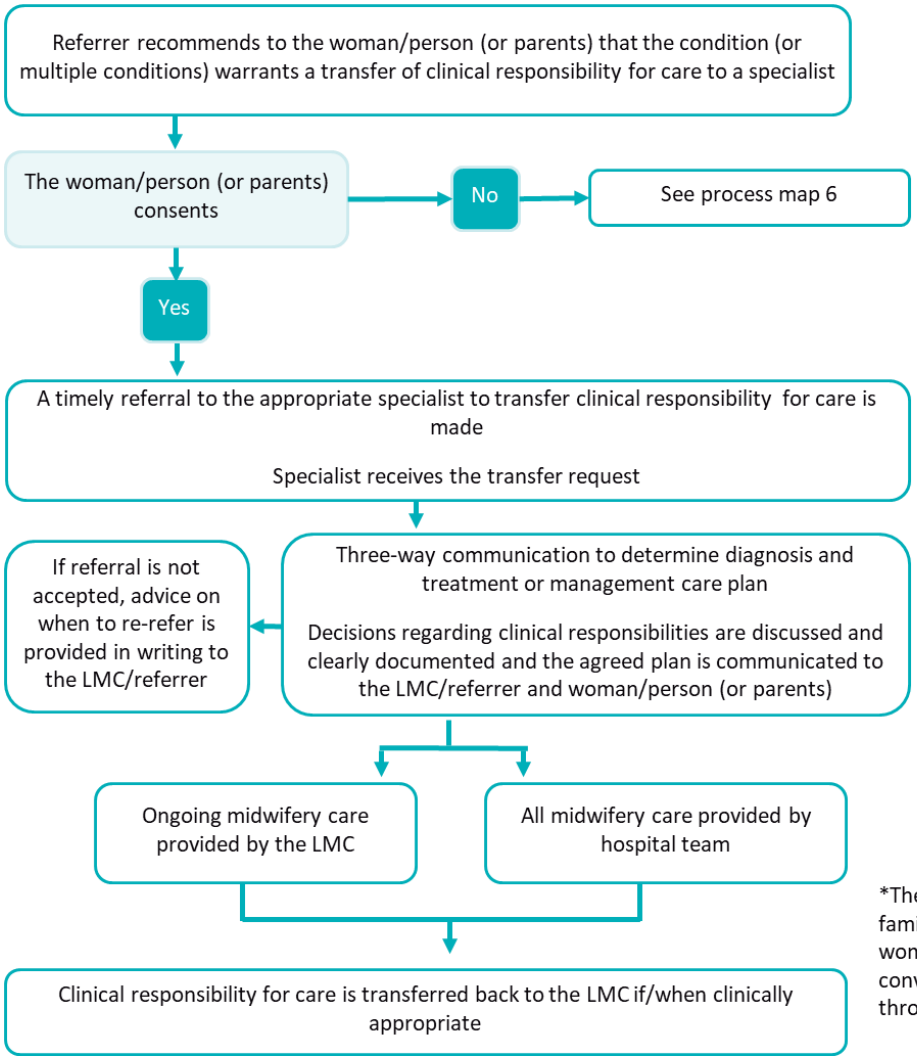
- capacity of local/regional secondary health care services to see women/people (or babies) in a timely manner
- access to the required specialist services in the area
- the distance, time and cost for the woman/person (or baby) to reach a hospital

- whether an in-person consultation with a hospital-based specialist (who may be located at the nearest main centre) is needed.

These factors should not influence whether transfer of clinical responsibility for care to a specialist is made but may be pertinent in deciding whether service capacity can meet a specific clinical need.

The steps in process map 3 should be reflected in local processes or protocols.

Process map 3: Transfer of clinical responsibility for care



*The woman/person, baby and family/whānau (as defined by the woman/person) are at the centre of all conversations and decisions about care through the process

Process for emergency transfer of clinical responsibility for care

Conditions listed in the emergency category are those that require immediate attention by the most appropriate health practitioner available. The type of health practitioner will depend on the specific condition and whether the emergency is taking place within a hospital, at a community maternity facility or in the community. The most appropriate health practitioner may include (but is not limited to):

- the LMC
- other midwives
- a GP or rural hospital doctor / rural generalist (obstetrics)
- paramedics
- obstetricians, either in person or by telephone if no obstetrician is on site or the emergency is taking place in the community or at a community maternity facility
- an obstetric registrar on site at a tertiary maternity service
- an anaesthetist, paediatrician or other relevant specialist.

Roles and responsibilities

The roles and responsibilities during the emergency will be defined by clinical need. Generally, the most experienced and relevant health practitioner will take the lead and advise others of what actions they should take. The LMC has the lead until such time as they transfer the clinical responsibility for care to the most appropriate health practitioner (where this is possible). An obstetric or neonatal emergency often but not always involves a transfer of clinical responsibility from an LMC if it requires transport to or occurs within a secondary or tertiary maternity facility.

The transfer of clinical responsibility for care must be clearly established and documented in the woman/person's or the baby's records at the time or as soon as practicable once the situation has stabilised.

Communication

Effective communication with the woman/person, parents and/or the whānau (as defined by the woman/person) is essential in an emergency. As much information as possible should be provided to the woman/person, parents and/or whānau, and to others responding to the emergency at that time.

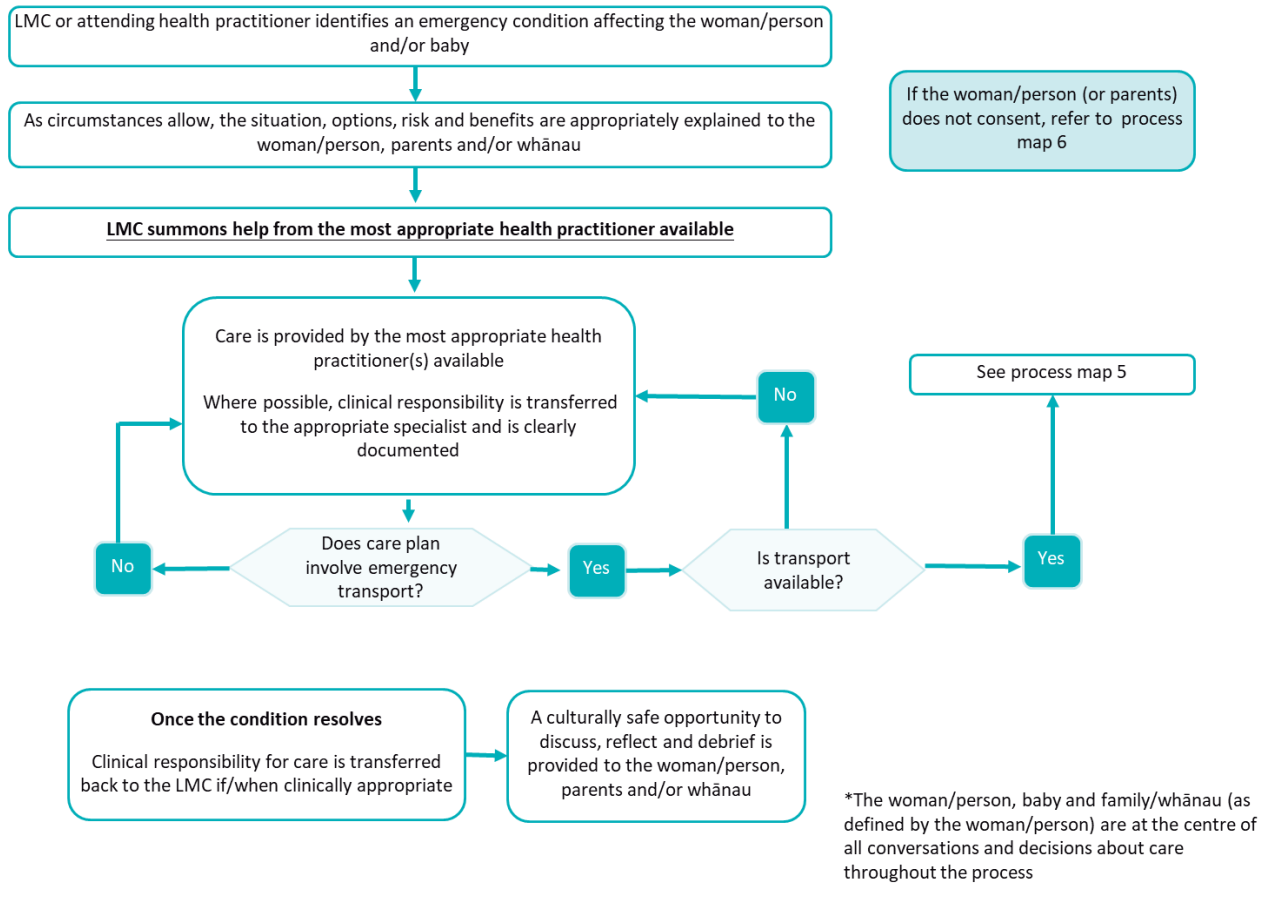
While it is not possible to discuss every potential emergency and its management, it is expected that the LMC will provided an overview of the management of obstetric or neonatal emergencies with the woman/person before such an emergency might occur.

Communication with the woman/person (or parents) may be difficult in some cases due to the nature of the emergency. Under right 7(4) of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, the health practitioner may provide services where it is in the best interests of the woman/person (or baby) and where reasonable steps have been taken to ascertain the woman/person's (or parents') views. This can be achieved through an antenatal conversation about emergencies documented in the clinical record and/or a birth plan. If the woman/person's (or parents') views are not clear, the health practitioner must consider the view of other suitable people who:

- are interested in the welfare of the woman/person and baby
- are available
- can appropriately provide the advice needed.

The steps in process map 4 should be reflected in local processes or protocols.

Process map 4: Emergency transfer of clinical responsibility for care



Process for emergency transport

Emergency transport refers to transport used in situations where the woman/person and/or the baby must be moved from the community to a secondary or tertiary maternity facility, or between secondary and tertiary facilities. During this period, the LMC may be consulting and working with other health practitioners as shown in process map 4. Transfer of clinical responsibility for care may have occurred before transport.

Clinical responsibility for care during emergency transport

Until care is formally transferred to a specialist, the LMC retains clinical responsibility for care. This means that paramedics or ambulance crew must take clinical direction from the LMC when they are responding to an obstetric or neonatal emergency.

If the LMC cannot provide a clinical escort during transport, clinical responsibility is transferred to the paramedic crew for the period of transport only. This clinical responsibility will normally be considered to have been transferred when the woman/person and/or the baby arrives at the secondary or tertiary maternity facility.

Emergency transport between maternity facilities

Health services have specific processes for requesting emergency transport from one facility to another. LMCs should ensure they are aware of the processes in their local area. For the purposes of the *Referral Guidelines*, maternity facilities include community maternity facilities, base hospitals and other facilities from which women/people and/or babies may need to be transported in the event of an obstetric or neonatal emergency.

If the agreed emergency transport process is not practical in the situation or is not available (for example, due to communication difficulties), LMCs should follow the procedure detailed in process map 5 for transport from the community to a secondary or tertiary facility.

Emergency transport resulting from a telephone consultation with a specialist

If an LMC consults with a specialist and a decision is made for emergency transport, the specialist decides on the most appropriate mode of transport in consultation with the emergency services and the LMC. The secondary or tertiary facility must inform the LMC of what transport to expect and the timeframe. The process is the same regardless of mode of transport (that is, air, water or road). If the woman/person and/or the baby is being transported in a private car, the LMC must explain this to the hospital team.

If the hospital team decides to use a retrieval team, the hospital team must inform the LMC the team is on its way and when it can be expected. Specific instructions should be provided to the LMC to maintain clinical safety until the team arrives.

LMC responsibilities before and during the emergency transport process

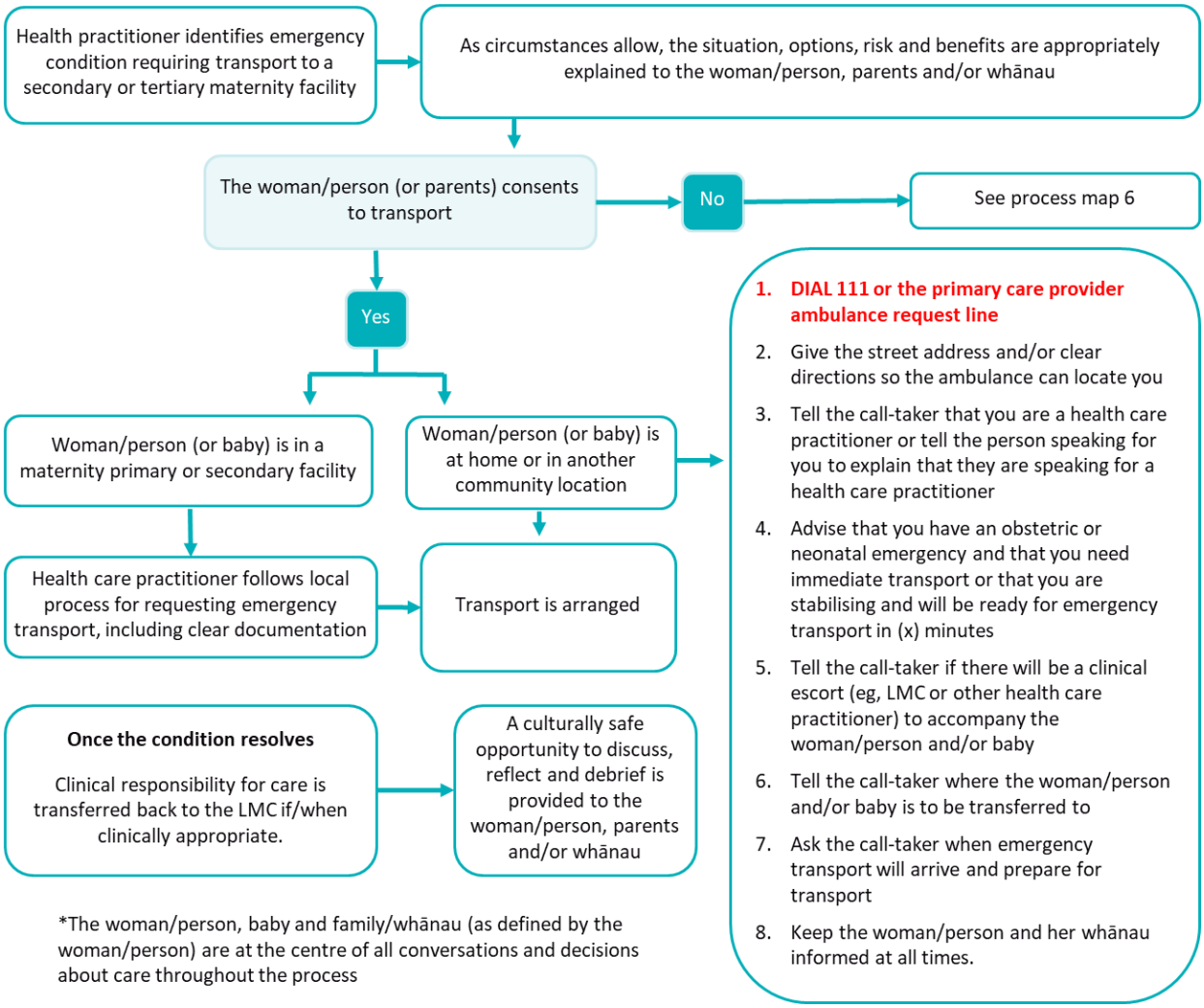
In preparation, all LMCs and core midwives employed at a community birthing facility should:

- be familiar with the process of arranging emergency transport in their locality and be familiar with the processes for emergency transfer of clinical responsibility for care (if required)
- provide care until emergency transport arrives
- ensure the woman/person and their support people understand the need for emergency transport and the emergency transfer of clinical responsibility for care (if required) and that the woman/person has provided consent (If the woman/person or parents do not consent to the emergency transport of their baby, please see 'The woman/person declines a referral, consultation, transfer of clinical responsibility for care or emergency treatment or transport' below)
- provide up-to-date clinical records and necessary administrative data to facilitate transport and transfer.[5]

The steps in process map 5 should be reflected in local processes or protocols.

[5] New Zealand College of Midwives. 2017. *Transfer Guidelines*. Christchurch: New Zealand College of Midwives.

Process map 5: Emergency transport



The woman/person declines a referral, consultation, transfer of clinical responsibility for care or emergency treatment or emergency transport

The right to informed consent, including the right to refuse medical treatment, is enshrined in law and in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (right 7). A woman/person (or parents) can choose to decline treatment, referral to another health practitioner, or transfer of clinical responsibility for care. To allow informed decision-making, right 6 of the Code requires that

the woman/person (or parents) receive accurate, honest information about the options available and the risks, side effects, benefits and costs of these options.

If a woman/person (or parents) chooses not to be referred or not to consult with a specialist, the health practitioner may be left operating outside their experience or scope of practice and/or may feel that they cannot provide the level of care the woman/person and/or baby needs. If, as a result, the health practitioner decides to remove themselves from that role, they must ensure that all relevant care is transferred appropriately.

If a woman/person (or parents) declines a referral, consultation or transfer of clinical responsibility for care, the health practitioner should:

- **ensure** that appropriate conversations about the situation, options, risks and benefits have occurred
- **clarify** with the woman/person (or parents) when it may be appropriate to revisit this decision (for example, a change in the clinical circumstances) and document this conversation in the woman/person's or the baby's records
- **explain** to the woman/person (or parents) that they need to consider discussing the case with at least one of the following (ensuring that the woman/person's and/or baby's right to privacy is maintained appropriately):
    - another midwife or GP
    - an appropriate specialist
    - an experienced colleague/mentor
- **share** the outcomes of any discussion that they have had and any resulting advice with the woman/person (or parents) and document this conversation in the woman/person's or the baby's records
- **document** the process, discussions, recommendations given and decisions made and the woman/person's (or parents) response in the care plan and note an alternative plan should the clinical condition change.

If, after this process, the health practitioner and the woman/person (or parents) have not reached agreement on satisfactory care arrangements, the health practitioner must decide whether to continue or discontinue care.

If the health practitioner decides to continue care, they should:

- **continue** making recommendations to the woman/person (or baby) for safe maternity care, including further offers of referral
- **engage** other health practitioners as appropriate for professional support (for example, secondary obstetric or neonatal service, other midwives, etc)

- **continue** to document all discussions and decisions in the woman/person's or baby's records.

If the health practitioner decides to discontinue care, they should:

- clearly communicate the decision and the reasons for that decision to the woman/person (or parents)
- help the woman/person (or parents) find alternative care within a reasonable timeframe
- provide a full handover to the new care provider
- provide the woman/person (or parents) with that provider's contact details and ensure that the woman/person (or parents) understands the changes to their maternity or the baby's care
- document the steps taken and that the woman/person (or baby) has been discharged from the health practitioner's care.

Obstetric or neonatal emergency

In an obstetric or neonatal emergency, the health practitioner cannot refuse to attend the woman/person and/or baby. If the woman/person declines emergency transport or transfer of clinical responsibility for care while in active labour, the health practitioner should remain in attendance. This may result in the health practitioner being called on to deal with a situation that is not within their scope of practice, may be outside their experience or ability to deal with safely or may require treatment that they cannot perform. In these situations, the health practitioner should:

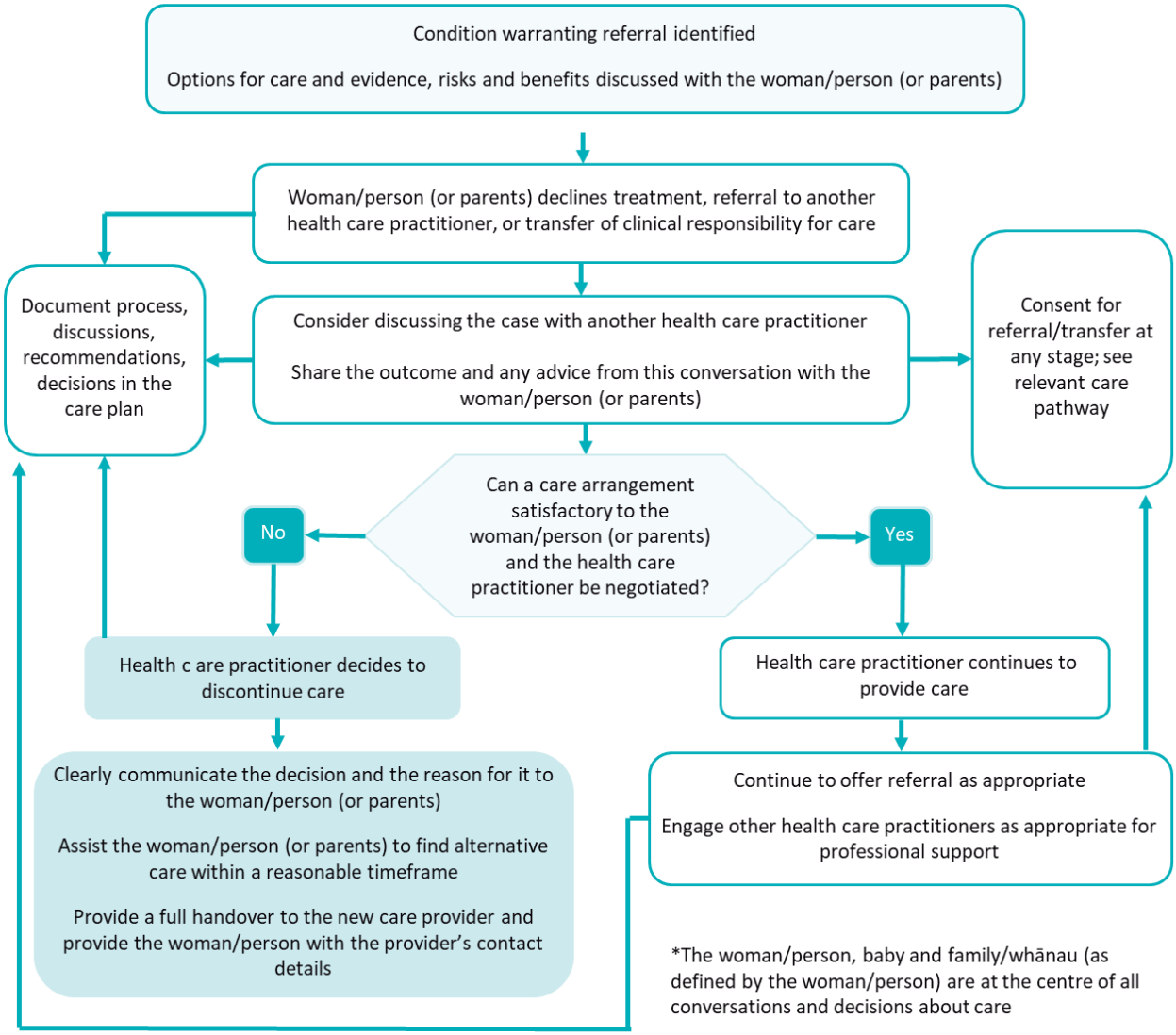
- provide care within professional standards
- provide care to the best of their ability
- attempt to access appropriate resources and/or personnel to provide any necessary care (dependent on the woman/person's consent)
- clearly document all discussions and actions in the woman/person's or the baby's records
- debrief with clinical colleagues after the event with appropriate support.

When the woman/person or parents decline care for their baby

Parents can decline care for their baby, but they cannot unreasonably withhold care for emergency treatment without which there is a risk of serious harm or death. If parents decline consent for treatment of the baby, health practitioners should discuss the baby's

needs and treatment options with the parents and whānau and document all advice given and actions taken in the baby's record.

Process map 6: Woman/person (or parents) declines treatment



Conditions and referral categories

Table 2: Conditions and referral categories provides a list of conditions for which a health practitioner should recommend to the woman/person (or parents) that a primary referral, consultation or transfer of clinical responsibility for care take place.

The referral categories are detailed in Table 1 and the processes that should be used are detailed in Table 2.

Health practitioners must use clinical judgement in deciding when and to whom to refer a woman/person and/or baby. For example, a condition that is normally a cause for a referral to a primary health care or allied health or kaupapa Māori service may be severe enough on presentation to warrant a specialist consultation. There may be multiple conditions that together warrant referral for consultation or a transfer of clinical responsibility for care.

The referral categories may form part of a continuum. Placing a condition in the consultation category does not preclude a subsequent transfer of clinical responsibility for care if that is indicated by the results of the consultation or if the condition persists or worsens.

All decisions concerning a woman/person's and/or the baby's care, including recommendations for referrals, consultations and/or transfer of clinical responsibility for care, must be made in discussion with the woman/person (or parents), and with all health practitioners involved in the care.

A woman/person and their LMC should discuss requests to have a consultation with a specialist or clinical responsibility for care transferred when there is no clinical indication.

Table 2: Conditions and referral categories

Code	Condition	Description	Referral category
Pre-existing and/or co-existing medical conditions			
Anaesthetics			
1001	Anaesthetic difficulties	Previous failure or complication (eg, difficult intubation, failed epidural, severe needle phobia)	Consultation

Code	Condition	Description	Referral category
1002	Malignant hyperthermia, neuromuscular disease or suxamethonium apnoea		Consultation
Autoimmune/rheumatology			
1003	SLE / connective tissue disorder	Active, major organ involvement, on medication	Transfer
1004		Inactive, no renal involvement, no hypertension, or only skin/joint problems	Consultation
1005	Thrombophilia including antiphospholipid syndrome	On warfarin, previous obstetric complications or maternal thrombosis	Transfer
1006		No previous obstetric complications or maternal thrombosis	Consultation
Cardiac			
1007	Arrhythmia, palpitations, murmurs	Recurrent, persistent or associated with other symptoms Note: Respiratory sinus arrhythmia does not require referral	Primary
1008	Cardiac valve disease	Mitral/aortic regurgitation	Consultation
1009		Mitral/aortic stenosis	Transfer
1011	Cardiac valve replacement		Transfer
1012	Cardiomyopathy		Transfer
1013	Congenital cardiac disease		Consultation
1014	Hypertension	Hypertension confirmed pre-conception or before 20 weeks' gestation with or without a known cause, measured on two or more occasions at least four hours	Consultation before 16 weeks' gestation

Code	Condition	Description	Referral category
		apart or on antihypertensive medication	
1015		Diastolic BP ≥110 mmHg or systolic BP ≥160 mmHg	Transfer
1016	Ischaemic heart disease.		Transfer
1017	Pulmonary hypertension		Transfer
Endocrine			
1019	Diabetes	Pre-existing (Type 1, Type 2, MODY)	Transfer
1020		Gestational, well controlled on diet or metformin	Consultation
1021		Gestational, requiring insulin	Transfer
1023	Hypopituitarism		Consultation
1076	Other known endocrine disorders significant in pregnancy	eg, Addison's disease, Cushing's disease	Consultation
1024	Prolactinoma		Consultation
1022	Thyroid disease	Hypothyroidism	Primary
1082		Hyperthyroidism	Consultation
Gastroenterology			
1077	Bariatric surgery		Consultation in the second trimester
1025	Cholecystitis	Presenting as acute abdominal pain	Consultation
1026	Cholestasis of pregnancy		Transfer
1029	Hepatitis	Acute	Consultation
1030		Chronic active	Consultation
1081		Active chronic on immunosuppressants	Transfer
1027	Inflammatory bowel disease	Active or on medication	Consultation
1028		Inactive	Primary

Code	Condition	Description	Referral category
1031	Oesophageal varices		Transfer
1072	Previous fatty liver in pregnancy		Consultation
Genetic			
1032	Any known genetic condition significant in pregnancy		Transfer
1033	Marfan syndrome		Transfer
Haematological			
1034	Anaemia	Hb < 90 g/L, not responding to treatment	Consultation
1036	Bleeding disorders	Including Von Willebrand disease	Consultation
1035	Haemolytic anaemia		Transfer
1039	Sickle cell disease		Transfer
1037	Thalassaemia		Consultation
1038	Thrombocytopaenia		Consultation
1040	Thromboembolism	Previous deep vein thrombosis, pulmonary embolism	Consultation
1041	Thrombophilia		Consultation
Infectious diseases			
1042	CMV/toxoplasmosis	Acute	Transfer
1044	HIV positive		Transfer
1045	Listeriosis	Acute	Transfer
1046	Rubella		Consultation
1047	Syphilis		Consultation
1048	Tuberculosis	Active	Transfer
1073		Contact	Primary
1049	Varicella	Acute	Transfer

Code	Condition	Description	Referral category
Mental health			
1058	Current alcohol or drug misuse / dependency		Primary
1078	Depression and anxiety disorders		Primary
1059	Other mental health condition	Stable and/or on medication, eg, bipolar disorder	Consultation
1079		Acute unstable psychosis	Transfer
1074		Complex mental health needs	Consultation
Neurological			
1050	Arteriovenous malformation, cerebrovascular accident, transient ischaemic attacks		Consultation
1051	Epilepsy	Controlled	Consultation
1052		Poor control or multiple medications	Transfer in first trimester
1075		New diagnosis	Transfer
1053	Multiple sclerosis		Consultation
1056	Muscular dystrophy or myotonic dystrophy		Transfer
1054	Myasthenia gravis		Transfer
1055	Spinal cord lesion		Transfer
Renal disease			
1061	Glomerulonephritis		Transfer
1062	Proteinuria	Chronic	Consultation
1063	Pyleonephritis		Consultation
1065	Renal abnormality or vesico-ureteric reflux		Consultation
1064	Renal failure		Transfer
Respiratory disease			

Code	Condition	Description	Referral category
1069	Acute respiratory condition		Primary
1067	Asthma	Moderate (using reliever more than twice per week)	Primary
1068		Severe (continuous or near continuous oral steroids or hospitalisation)	Consultation
1071	Chronic obstructive pulmonary disease (COPD)		Consultation
1070	Cystic fibrosis		Transfer
Transplant			
1080	Organ transplant		Transfer
Previous gynaecological conditions or surgery			
2001	Cervical surgery, including cone biopsy, laser excision or large loop excision of the transformation zone (LLETZ)	One LLETZ procedure with known depth excision ≥10 mm without subsequent term vaginal birth or more than one LLETZ procedure and/or cold knife cone biopsies	Consultation before 16 weeks' gestation
2003	Congenital abnormalities of the uterus	Without previous term pregnancy outcome	Consultation before 16 weeks' gestation
2011	Female genital mutilation		Consultation
2007	Previous uterine surgery	Myomectomy	Consultation
2008		Previous uterine perforation	Consultation
2009	Prolapse	Previous surgery	Consultation
2010	Vaginal abnormality	eg, septum	Consultation
Previous maternity history			
3002	Alloimmune thrombocytopaenia	As risk to fetus of thrombocytopaenia	Transfer
3003	Caesarean section		Consultation
3019	Fetal congenital abnormality		Consultation

Code	Condition	Description	Referral category
3023	Fetal growth restriction	Born ≥ 20+0 weeks with neonatal *FGR diagnosis	Consultation before 16 weeks' gestation
3008	Hypertensive disease	Commence aspirin between 12 and 16 weeks' gestation Pre-eclampsia with significant fetal growth restriction (FGR) or requiring birth < 34 weeks' gestation	Consultation before 16 weeks' gestation
3021		Commence aspirin between 12 and 16 weeks' gestation Previous eclampsia or HELLP	Consultation before 16 weeks' gestation
3011	Manual removal	With adherent placenta, consider previous management of third stage	Consultation
3020	Obstetric anal sphincter injury	3a, 3b, 3c and 4th degree tearing, with or without symptoms	Consultation
3012	Perinatal death		Consultation
3013	Postpartum haemorrhage	> 1000 mL	Consultation
3017	Previous dilation and curettage	Previous complications or three or more procedures	Consultation before 16 weeks' gestation
3001	Previous placental abruption		Consultation
3014	Previous spontaneous preterm birth	Between 16 and 31+6 weeks' gestation	Consultation before 16 weeks' gestation
3022		Between 32 and 6+6 weeks' gestation	Consultation before 26 weeks' gestation

Code	Condition	Description	Referral category
3015	Recurrent miscarriage	Three or more	Consultation before 16 weeks' gestation
3016	Shoulder dystocia		Consultation
3018	SUDI (Sudden unexplained death in infancy)		Primary
3005	Trophoblastic disease	Hydatidiform mole or vesicular mole, within last 12 months	Consultation
Current pregnancy			
4001	Acute abdominal pain		Consultation
4002	Abdominal trauma		Consultation
4003	Abnormal CTG		Consultation
4004	Antepartum haemorrhage		Consultation
4005	Blood group antibodies		Consultation
4017	Class II obesity	Body mass index (BMI) 35–40 kg/m^2	Consultation
4034	Class III obesity	BMI 40–49 kg/m^2; include an anaesthetic consultation	Consultation
4035	Class IV obesity	BMI $\underline{\geq}$ 50 kg/m^2; include an anaesthetic consultation	Transfer
4046	Contraceptive device in-situ	Includes both intrauterine devices/systems and implants	Consultation in first trimester
4047	COVID-19 Refer to heath pathway for risk stratification	Active infection	Consultation
4036		Previous infection this pregnancy	Consultation
4006	Eclampsia		Emergency
4007	Fetal abnormality		Consultation
4008	Gestational proteinuria	Protein creatinine ratio $\underline{\geq}$ 30	Consultation

Code	Condition	Description	Referral category
4009	Gestational hypertension	New onset hypertension after 20 weeks' gestation without signs of pre-eclampsia; systolic BP ≥140 mmHg or diastolic BP ≥90 mmHg measured on two or more occasions at least four hours apart	Consultation
4029	Herpes genitalis	Active lesions	Consultation
4033	Influenza-like illness		Primary
4010	Intrauterine death		Transfer
4048	Fetal growth restriction	Early-onset (< 32+0 weeks) *EFW customised or *AC < 3rd centile or *UA with absent or reversed end-diastolic flow or *EFW customised or *AC < 10th centile AND abnormal Doppler (*UA and/or *UtA)	Consultation
4049		Late-onset (≥ 32+0 weeks) *EFW customised or *AC < 3rd centile or two or more of: • *EFW customised or *AC < 10th centile • slowing fetal growth (*EFW or *AC decline > 30 centiles from 28+0 weeks) • abnormal Doppler (*UA, *CPR and/or *UtA)	Consultation

Code	Condition	Description	Referral category
4050		*EFW < 3rd centile OR at risk of birth < 28+0 weeks' gestation or at risk of birthweight < 1,000g	Transfer
4051	Isolated small for gestational age (SGA)	EFW and/or AC 3rd to <10th centile with normal Doppler measurements.	Consultation
4013	Infant large for gestational age	EFW > 90th centile and AC > 90th centile, in the absence of diabetes	Consultation
4015	Malignancy		Transfer
4016	Malpresentation	> 36 weeks' gestation; breech, transverse, oblique or unstable lie	Consultation
4018	Multiple pregnancy	Dichorionic twins	Transfer
4037		Monochorionic twins and higher order multiples	Transfer at diagnosis
4019	Oligohydramnios	No pool depth ≥ 2 cm	Consultation
4038	Parvovirus B19 infection		Consultation
4020	Placenta praevia; vasa praevia	≥ 32 weeks' gestation	Transfer
4039	Polycystic kidneys	Maternal (not fetal) finding	Consultation
4021	Polyhydramnios	Mild (deepest pocket measurement 9–11 cm)	Consultation
4040		Moderate (deepest pocket measurement 12–15 cm) or severe (deepest pocket measurement > 16 cm)	Transfer
4022	Pre-eclampsia	New onset hypertension after 20 weeks' gestation (systolic BP ≥ 140 mmHg or diastolic BP ≥ 90 mmHg measured on two or more occasions at least four hours apart) with	Transfer

Code	Condition	Description	Referral category
		one or more of the following: proteinuria ≥ 30 mg/mmol, other organ dysfunction (renal, liver, neurological, haematological), or uteroplacental dysfunction (for example, fetal growth restriction, abruption)	
4023	Preterm rupture of membranes	< 37+0 weeks' gestation and not in labour	Transfer
4024	Prolonged pregnancy	Refer in a timely manner for planned induction by 42 weeks gestation	Consultation
4025	Premature labour	Between 34 and 36+6 weeks gestation	Consultation
4026		< 34 weeks' gestation	Transfer
4027	Pre-labour rupture of membranes at term	Consult before 24 hours	Consultation
4028	Persistent reduced fetal movements	Following normal cardiotocograph but still reduced movements – may require a scan for liquor assessment/ growth assessment	Consultation
4041	Short cervix	Finding on ultrasound of a cervix < 25 mm before 24 weeks' gestation	Consultation as soon as possible after detection
4045	Syphilis	First diagnosed in current pregnancy	Consultation
4042	Thromboembolism	Deep vein thrombosis, pulmonary embolism	Emergency
4044		Investigated for possible DVT or PE (negative result)	Consultation
4032	Urinary tract infection (UTI)	Recurrent	Consultation

Code	Condition	Description	Referral category
4031	Uterine fibroids	Cervical fibroids, retroplacental fibroids, submucosal or intramural fibroids > 5 cm, multiple fibroids	Consultation
4043	Velamentous cord insertion		Consultation
Labour and birth – first and second stage			
5001	Amniotic fluid embolism		Emergency
5002	Anhydramnios		Transfer
5003	Cerebral anoxia / cardiac arrest		Emergency
5004	Complications of anaesthetic		Consultation
5005	Complications of other analgesia		Consultation
5007	Cord prolapse or presentation		Emergency
5008	Deep transverse arrest		Transfer
5009	Epidural		Consultation
5011	Fetal heart rate abnormalities		Consultation
5012	Hypertonic uterus		Consultation
5013	Induction of labour		Consultation
5010	Instrumental vaginal birth		Transfer
5016	Intrapartum haemorrhage		Transfer
5027	Labour requiring oxytocin augmentation		Consultation
5006	Malpresentation	Compound presentation	Transfer
5028		Breech diagnosed in labour	Transfer
5017	Maternal tachycardia	Sustained	Consultation
5018	Meconium liquor	Moderate or thick	Consultation
5019	Obstetric shock		Emergency
5020	Obstructed labour		Transfer

Code	Condition	Description	Referral category
5021	Prolonged first stage of labour	< 2 cm in four hours for nullipara. Slowing in the progress of labour for second and subsequent labours. Take into consideration descent and rotation of fetal head and changes in strength, duration and frequency of contractions	Consultation
5023	Prolonged active second stage of labour	> two hours of active pushing with no progress for nullipara or > one hour of active pushing with no progress for multipara	Consultation
5024	Pyrexia in labour	> 38 degrees with or without fetal tachycardia	Consultation
5025	Shoulder dystocia		Emergency
5026	Uterine inversion		Emergency
Labour and birth – third stage			
6001	3rd and 4th degree lacerations		Transfer
6002	Cervical laceration		Transfer
6003	Postpartum haemorrhage (PPH)	> 500 mL of blood loss with ongoing losses	Consultation
6008		Ongoing uncontrolled bleeding	Emergency
6004	Retained placenta		Transfer
6005	Shock		Emergency
6006	Vaginal laceration	Complex	Consultation
6007	Vulval and perineal haematoma		Transfer
Following birth – woman/person			
7001	Breast infection	Suspected abscess or not settling with antibiotics	Consultation

Code	Condition	Description	Referral category
7002	Neonatal death	Discussion and plan	Consultation
7003	Post-birth neurological deficit	eg, neuropraxia	Consultation
7004	Postnatal depression		Primary
7005	Postnatal psychiatric event	Including bipolar, psychosis	Transfer
7007	Pyrexia of unknown origin		Consultation
7008	Secondary PPH		Consultation
7006	Sepsis	>38°C or <36°C; heart rate > 100 beats per minute; respiratory rate > 25 breaths per minute; systolic blood pressure < 90 mmHg; new onset of pain; altered mental state	Transfer
7009	Suspected epidural abscess or haematoma	May overlap with 7003	Emergency
7010	Suspected post-dural puncture headache		Consultation
7011	Recall or awareness under general anaesthesia		Consultation
7012	Vaginal or perianal prolapse		Consultation
Following birth – baby			
General			
8001	Abnormal neonatal examination	Minor abnormalities not specified elsewhere	Primary
8074	Abnormal pulse oximetry screen result	Persistent oxygen saturation 90–94% on third test	Consultation
8075	Abnormal red eye reflex	As per the red reflex screening assessment	Consultation
8057	Birth injury		Consultation
8003	Congenital anomaly	Conditions that may require early treatment	Consultation

Code	Condition	Description	Referral category
8002	Fetal ultrasound abnormality	Any	Consultation
Cardiovascular			
8058	Absent femoral pulses		Consultation
8004	Heart murmur, no symptoms		Consultation
8005	Heart murmur with symptoms		Transfer
8059	Hypoxaemia	< 90% oxygen saturation	Consultation
8006	Persistent or recurrent cyanosis		Transfer
8060	Persistent tachycardia		Consultation
CNS			
8008	Convulsions or unresponsiveness		Emergency
8009	Excessive irritability		Consultation
8010	Limpness, hypotonic	With abnormal vital signs or other abnormality	Emergency
8069		With normal vital signs	Consultation
8007	Microcephaly	Occipitofrontal head circumference < 3rd percentile	Consultation
8011	Severe infant depression at birth	eg, Apgar score of ≤ 6 at 1 minute with little improvement by 10 minutes	Emergency
8072	Moderate infant depression at birth	eg, Apgar score of ≤ 6 at 10 minutes	Transfer
Gastrointestinal			
8024	Abdominal distension or mass		Consultation
8027	Inguinal hernia		Consultation
8026	No passage of meconium by 36 hours		Consultation
8025	Persistent or bile-stained vomiting		Consultation

Code	Condition	Description	Referral category
8070	Persistent fresh blood in stools		Consultation
8023	Suspected oesophageal atresia	Unable to pass a gastric tube in a mucousy baby	Transfer
Genitourinary			
8062	Ambiguous genitalia		Consultation
8063	Antenatal genitorenal renal dilation	Anterior-posterior renal pelvic diameter (AP RPD) < 15 mm with no peripheral dilatation or additional findings (P1)	Primary
8064		AP RPD ≥15 mm or with no peripheral dilatation or additional findings OR AP RPD <15 mm with peripheral dilatation (P2)	Consultation
8065		Antenatal AP RPD > 7mm with central calyceal dilation (A2) or postnatal AP RPD ≥15 mm with peripheral dilatation or additional findings or any AR RPD with additional findings (P3)	Consultation
8028	Failure to pass urine in the first 24-hour period		Consultation
8029	Hypospadias or foreskin abnormality		Consultation
8030	Undescended testes		Primary
Growth and feeding			
8014	Dehydration or > 10 - 12.5% weight loss since birth		Consultation
8061	Weight loss of > 12.5% since birth		Transfer
8016	Fetal growth restriction	Customised *BW < 3rd centile or customised *BW ≥ 3 to < 10 centile and ≥ 2 of:	Consultation

Code	Condition	Description	Referral category
		• *BMI z-score < -1.3 • length z-score < -1.3 • skin/body fat z-score < -1.3 (where equipment and expertise allow) • antenatal *FGR diagnosis • major *FGR risk factor • placental insufficiency on histology or customised *BW ≥ 10 centile, antenatal *FGR diagnosis and evidence of placental insufficiency	
8017	Low birthweight	Birthweight 2,000–2,500 g	Consultation
8018		Birthweight < 2,000 g	Transfer
8015	Persistent vomiting without blood or bile		Consultation
8019	Poor weight gain	Birthweight not regained by 14 days	Consultation
8021	Preterm	Between 35+0 and 36+6 weeks' gestation	Consultation
8022		< 35 weeks' gestation	Transfer
8013	Sustained feeding difficulties in a newborn not related to gestational age		Consultation
Haematology			
8031	Evidence of a bleeding tendency	Haematemesis, melaena, haematuria, purpura, generalised petechiae	Transfer
8032	Haemorrhage from cord or another site		Transfer
8033	Maternal isoimmunisation	Rhesus or other antibodies Refer before birth	Transfer

Code	Condition	Description	Referral category
8034	Maternal thrombocytopaenia		Consultation
8066	Neonatal subgaleal haemorrhage	Normal vital signs and head circumference stable with no signs of ongoing bleeding	Transfer
8067		Any concern about baby's vital signs OR signs of ongoing bleeding OR head circumference increasing	Emergency
Infection			
8076	COVID-19	Current infection	Consultation
8073	Sepsis		Consultation
8036	Suspected chorio-amnionitis	Fetal tachycardia, maternal pyrexia, offensive liquor	Consultation
8037	Temperature instability	Temp < 36.5°C or > 37.5°C confirmed within one hour following appropriate management	Consultation
Jaundice			
8038	Any in first 24 hours		Transfer
8039	Bilirubin > 250 micromol/L in first 48 hours		Consultation
8040	Bilirubin > 300 micromol/L at any time		Consultation
8041	Prolonged jaundice: visible or > 150 micromol/L from two weeks in term infant and three weeks in preterm infant		Consultation
8042	Significant jaundice in previous infant		Consultation
Maternal factors			
8043	Infant of a woman/person with history of substance or alcohol	eg, methadone, marijuana, alcohol, codeine, valium, methamphetamines	Consultation

Code	Condition	Description	Referral category
	misuse/ dependence in this pregnancy		
8044	Infant of woman/person with diabetes	Hypoglycaemia (blood sugar < 2.0 mM)	Transfer
8068		Hypoglycaemia (blood sugar 2.0–2.5 mM)	Consultation
8045		Apparently normal infant or with abnormal findings other than hypoglycaemia	Consultation
8046	Intrauterine infection	Toxoplasmosis, rubella, cytomegalovirus (CMV), other Referral before birth often appropriate	Consultation
8048	Maternal medication with risk to baby	eg, carbimazole, antipsychotics, antidepressants, anticonvulsants	Primary
8077		Lithium-based medications	Consultation
8049	Maternal or family history with risk factors for baby	eg, vesico-ureteric reflux, bleeding disorder, congenital heart disease, deafness, Graves' disease, syphilis, severe handicap in parent, bipolar disease, schizophrenia, other psychiatric condition	Consultation
Orthopaedics			
8051	Congenital hip problem	Unstable hips, breech birth, family history of dislocated hips	Consultation
8052	Congenital foot problem	Talipes equinovarus or significant positional foot deformity	Consultation
Respiratory			

Code	Condition	Description	Referral category
8054	Apnoea	Baby has stopped breathing for more than 20 seconds and needs resuscitation	Emergency
8071		Repeated pauses in breathing (> 10 seconds)	Transfer
8055	Persistent tachypnoea	Respiratory rate > 60/min for more than one hour from birth	Consultation
8053	Respiratory distress	Any cyanosis, persistent grunting, pallor	Transfer
8056	Stridor, nasal obstruction or respiratory symptoms not specified elsewhere	With normal O_2 saturation (> 95%)	Consultation
8078		With low O_2 saturation (< 90%)	Transfer

*AC= abdominal circumference; BMI = body mass index; BW = birthweight; CPR = cerebroplacental ratio; EFW = estimated fetal weight; FGR = fetal growth restriction; UA = umbilical artery; UtA = uterine artery.

Further advice on Te Tiriti

The professional associations can offer helpful support for health practitioners around giving effect to the principles of Te Tiriti, for example:

- Medical Council of New Zealand: **Statement on cultural safety**
- Medical Council of New Zealand: **He Ara Hauora Māori: A pathway to Māori health equity**
- Midwifery Council of New Zealand: ***Statement on Cultural Competence for Midwives***
- Ngā Maia Turanga Kaupapa, principles that give life and meaning to the midwifery profession's recognition of Māori as tangata whenua and the profession's obligations under Te Tiriti, in the *Midwives' Handbook for Practice*
- The Royal Australasian College of Physicians: ***Guideline Commentary On Consulting With Māori And Their Whānau***.

Health practitioners may also find it valuable to familiarise themselves with:

- Medical Council of New Zealand: ***Best Health Outcomes for Māori: Practice implications*** (Māuri Ora Associates 2006)
- Huria T, Pitama S, Lacey C. 2014. **Improving Māori health through clinical assessment: Waikare o te waka o meihana**. *The New Zealand Medical Journal, 127*(1393)
- Continuing Education, University of Otago: MIHI 501 Health Professionals Course: **Application of the Hui Process / Meihana Model to Clinical Practice**.

Cultural safety

Practising in a culturally safe way is important and a requirement of Te Tiriti, particularly in giving effect to the principles of active protection, options and partnership. Health practitioners must know that tikanga or correct protocols and practices are often specific to whānau, hapū and iwi and that observing tikanga does not involve a 'one-size-fits-all' approach. Similarly, mātauranga Māori or Māori knowledge is not a single entity; rather there is both traditional and contemporary mātauranga Māori, as well as mātauranga Māori that is specific to hapū and iwi environments, including land, seas, waterways, weather systems, the stars, flora and fauna, and things seen and unseen. Older forms of mātauranga Māori have been somewhat protected from colonisation because they were composed or narrated in te reo Māori.

Rangatiratanga or self-determining rights over tikanga and mātauranga Māori is crucial to the safety and survival of mātauranga Māori. For this reason, health practitioners should be very careful to avoid imposing their understanding of tikanga or mātauranga Māori on Māori through maternity care. In addition, they should not assume that all Māori are familiar with terms such as ‘tikanga’, ‘mātauranga’ and ‘Te Tiriti’. Māori who are unfamiliar with such terms can experience such an assumption as diminishing their mana[6] as expressed by Te Tiriti, which would be an outcome that is the opposite of the intent of Te Tiriti, this guideline and Ngā Paerewa.

[6] Te Tiriti o Waitangi framework as set out in: Ministry of Health. 2020. Whakamaua: Māori Health Action Plan 2020–2025. Wellington: Ministry of Health.

Update process

The Ministry of Health contracted consultants Allen + Clarke to update the 2012 *Referral Guidelines*. Our project team (Anna Gribble, Professor Frank Bloomfield, Dr Michelle Wise and Norma Campbell) is grateful for the advice and guidance received from the health and disability sector in response to draft documents.

Three literature reviews addressing three research questions were completed to inform the update of this guideline. Recommendations were developed by expert consensus, considering the evidence from the reviews of relevant clinical literature.

We wish to acknowledge and thank the Maternity Guidelines Review Steering Group for its advice and guidance. Members of the Maternity Guidelines Review Steering Group were:

- Dr Angela Beard (Co-Chair, He Hono Wāhine)
- Sue Bree (Co-Chair, Midwifery Leaders' Group)
- Claire MacDonald (New Zealand College of Midwives)
- Dr Karaponi Okesene Gafa (Royal Australian and New Zealand College of Obstetricians and Gynaecologists, RANZCOG)
- Dr Lesley Dixon (New Zealand College of Midwives)
- Liz Lewis-Hills (New Zealand Society for the Study of Diabetes)
- Dr Mariam Buksh (Royal Australasian College of Physicians)
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- Dr Rachael McConnell (RANZCOG)
- Dr Rosemary Hall (New Zealand Society for the Study of Diabetes)
- Dr Sue Belgrave (RANZCOG)
- Dr Trevor Lloyd (The Royal New Zealand College of General Practitioners).

The *Referral Guidelines* are due for their next review in 2027.