

Signature Page for Newborn Care

The following tests and/or treatments are standard care for the newborn, but families receiving care at Mother's Own Birth and Women's Center may decide whether they wish to have these done. Please read the information sheet for each of these tests before declining any of these tests or treatments. Please initial and date each section.

Erythromycin Eye Ointment

_____ We have been advised that if gonorrhea or chlamydia is present in the mother at the time of birth, the infant may develop an infection of the eyes. Such an infection may not be treatable and may result in the baby's permanent blindness. We understand that no test can be done on a mother close enough to the time of birth to rule out the possibility of these infections. We understand that if 1.0% erythromycin ophthalmic ointment or other appropriate medication is put in each eye of a newborn immediately after birth (within the first hour), the danger of infection and blindness is prevented.

Although we understand the risk, we object to the treatment for the following reasons:

Vitamin K Injection

_____ **Yes**, our newborn child is to receive an injection of vitamin K before discharge.

_____ **No**, we do not want our newborn to receive prophylactic vitamin K unless there are risk factors for developing VKDD/VKDB.

OR

_____ **No**, we do not want our newborn to receive an injection of vitamin K before discharge. We are aware of the signs and symptoms of VKDD/VKDB as listed in the information sheet. Although we understand the risks, we object to the treatment and request that vitamin K be withheld for the following reasons:

Newborn Metabolic Screening

_____ We understand that the States of Michigan and Ohio require all facilities and/or providers to perform a Newborn Metabolic Screen. We have been advised that conditions screened for are hereditary diseases of an enzyme or hormone deficiency that we may have passed on to our child. Undetected and untreated, these diseases lead to early and permanent brain damage, physical deformities or death.

We have been informed that a screening blood test done on our baby within the first 24- 72 hours after birth can detect the additional risk of these diseases. If these diseases/conditions are diagnosed early, they can be successfully treated without permanent damage.

Although we understand the risk, we object to the performance of the newborn screening test on our child and request that it be withheld for the following reasons:

We assume all responsibility for these decisions, and for any and all medical consequences that may result from them. We will not hold the midwives or their medical consultants in any way responsible for our decision to omit this testing or treatments.

Signature of mother: _____ Date: _____

Signature of father/partner _____ Date: _____

Signature of CNM: _____ Date: _____

Pediatric Provider

Physician or NP _____

Practice Name _____

Address _____

City, State, Zip code _____

Phone _____ Fax _____