Maternity Options Of Miami

Newborn Care Plan

Parent directions: Please Return Newborn Forms to MOM by 34 Weeks

Mother's Full Name: _____ DOB: _____

Partner's Full Name: _____ DOB: _____

Acknowledgement of Paternity - Required by CO if parents not married at time of birth.

- Completed? YES / Does not apply

Newborn Primary Care (Pediatrician) Provider

Please identify below your chosen pediatrician.

Name: _____ Phone: _____ Fax: _____

For Newborn Care Provider Authorization to Disclose Health Information – completed? YES / NO

Newborn's Insurance Details

Name: _____

Policy Holder Name: _____ Subscriber DOB:_____

Relation to Newborn: _____

Subscriber # _____ Group # _____

Copy of card provided to MOM? YES / NO / SAME AS MOTHER

BY SIGNING YOU AGREE: I certify to the accuracy of the above information. I authorize my medical care provider and/or her billing company to release any information necessary in order to process my claims. I authorize my insurance company or third-party payer to release payment of benefits to my provider.

Mother's Signature _____ Date _____

Primary Insured Party (if not mother) _____ Date _____

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HIPAA Authorization to Disclose Medical Information of Newborn

Authorization to disclose protected health information to family members or others:
I authorize disclosure of my newborn's protected health information (PHI) for purposes of communicating results, findings, and care decisions to my newborn's family members and others as indicated below. I acknowledge that no information regarding my newborn's healthcare can be communicated without my permission unless I become incapacitated. If I become incapacitated healthcare providers will communicate to individuals assigned in advanced directives previously designated by me. If no advanced directive has been designated, I acknowledge that healthcare providers will communicate to my proxy decision maker, legal guardian or next of kin as listed below.

NAME	RELATIONSHIP	PHONE NUMBER

Consent for Treatment of Newborn

Mother's Name: _____ DOB: _____

I (We) as parent(s) of our child Baby Boy or Baby Girl _____ (surname), grant permission for Maternity Options of Miami to provide medical care as deemed necessary to the above named dependent, effective from (initial date) _____ through (date) _____. (Recommendation: Initial date start of 37 weeks gestation through 6 weeks postpartum,)

Mother's signature: _____ Date: _____

Father/Legal Guardian's signature: _____ Date: _____

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Vitamin K

Newborn babies are born with little vitamin K and breastmilk is low in vitamin K. At birth the baby's intestinal tract has no bacteria to make the vitamin, but throughout the first week of life bacteria levels and vitamin K levels naturally increase. Newborns are routinely given a vitamin K injection in most hospitals to prevent Vitamin K Deficiency Disease, a rare but deadly bleeding condition. This type of internal bleeding in a newborn can lead to internal damage, brain damage and even death if undetected. The injection is given in the first hour of life. THIS IS NOT A VACCINATION. Vitamin K deficiency symptoms occur in approximately 6/100,000 newborns who don't receive any supplementation; some statistics quote as high as 1/100 newborns. Some parents object to their newborn receiving painful routine injections; some dislike the preservatives in the injections, some dislike giving a coal tar derivative.

Oral vitamin K decreases the incidence of bleeding problems, but is not as effective as the injection and it is not the standard of care approved by the American Academy of Pediatrics. We are not sure if Vitamin K Deficiency in the newborn can be prevented by a good maternal diet. It seems there is probably a genetic component to this disease as well. Any baby treated with oral Vitamin K or not treated at all should be watched carefully for any bruising of the baby's skin or any unusual discoloration or lesions on the baby's skin. These may occur up to 3 months after birth. If this occurs the baby should be evaluated immediately and the pediatric care provider informed that the baby did not receive a Vitamin K injection. The treatment is a Vitamin K injection given at that time. It may be possible for a newborn to have a case that is not detectable. Maternal or newborn antibiotic use close to birth may make a baby more susceptible to Vitamin K Deficiency since antibiotics can kill the bacteria in the intestines that manufacture the vitamin.

Please be aware that if you are choosing to circumcise your baby boy, pediatric providers will require your baby receive the Vitamin k injection, or they may refuse to perform the procedure.

Choose ONE of the following, then complete the signature portion below:

_____ I want a Vitamin K injection given to my newborn within one hour of birth

_____ I want my baby to receive oral Vitamin K at birth, at one and three days of age and at two and six weeks of age. I have been advised to watch the baby's skin for bruising and/or unusual skin lesions and to report these immediately to the pediatric care provider and inform them the baby did not receive a Vitamin K injection after birth. **I am responsible for ordering oral Vitamin K and I am aware that "MOM" does not supply oral Vitamin K**

_____ I do not want Vitamin K given to my baby in any form. I have been advised to watch the baby's skin for bruising and/or unusual skin lesions and to report these immediately to the CNM or my pediatric care provider and inform them the baby did not receive a Vitamin K injection after birth.

_____	_____	_____
Client Printed Name	Signature	Date
_____	_____	_____
Other Parent Printed Name	Signature	Date

Maternity Options Of Miami

Erythromycin Ophthalmic Ointment

This is an antibiotic eye ointment routinely given to newborns in the hospital. It is given to prevent eye infections that could result in blindness. If a mother has Gonorrhea or Chlamydia the baby may get infected at birth. Most women have been tested for these sexually transmitted diseases as part of their routine prenatal care. Women at high risk for these diseases would be wise to have the newborn treated routinely. Some parents who are certain they are not infected refuse routine treatment. Any baby, whether treated or not, needs to be evaluated if any signs of infection develop in the baby's eyes after birth.

1. 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.
2. 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.
3. We understand that is 1.0% erythromycin ophthalmic ointment or other appropriate medication is put in the eye of a newborn immediately after birth, the danger of infection and blindness is prevented.

4. We assume all responsibility for this decision, and for any and all medical consequences that may result from it. We will not hold Maternity Options of Miami, the midwifes or their medical consultants in anyway responsible for our decision to withhold eye prophylaxis

Please choose one option below.

_____ I want my baby to receive antibiotic eye ointment within one hour of birth

_____ I refuse routine eye antibiotics and will notify the Midwife and the pediatric care provider of any unusual eye discharge that I notice.

_____	_____	_____
Client Printed Name	Signature	Date
_____	_____	_____
Other Parent Printed Name	Signature	Date

Maternity Options Of Miami

Consent for Participation in Student Education

In an effort to promote knowledge and acceptance of birth center care among healthcare professionals, Maternity Options of Miami, LLC encourage the involvement of students in our program. These include nurse-midwifery, nursing, and medical students. Their roles range from observation to full participation in all aspects of client care. Students are closely supervised by a CNM, LM, or RN at all times.
No student may be involved in your care without your express permission. Student involvement will be discussed with you, and permission obtained by the midwife. If at any point you wish to change your decision regarding student involvement, you may do so by notifying the midwife of your wishes.

If you wish to limit student participation in your care, or to refuse any student involvement, you should feel free to do so. We hope, however that you will consider helping us educate students about the unique care provided in a setting such as ours.

_____ I agree to student participation in my care

_____ I refuse student participation in my care.

_____	_____	_____
Client Printed Name	Signature	Date
_____	_____	_____
Other Parent Printed Name	Signature	Date
_____	_____	_____
Midwife Printed Name	Signature	Date

Maternity Options Of Miami

Newborn Metabolic Screening

PKU screening, or Phenylketonuria screening is a standard procedure conducted shortly after birth to detect a rare genetic disorder that affect how the body processes a specific amino acid called phenylalanine. The disorder, if left untreated, can lead to intellectual disabilities and other serious health issues. This consent ensures that parents understand the purpose of the screening and agree to it being performed on their newborn. The screening involves a simple blood test, usually performed by pricking the baby's heel to collect a small sample of blood. Early detection through PKU screening allows for prompt intervention and treatment, significantly improving the long-term outcomes for affected individuals.

1. I have been advised that phenylketonuria, hypothyroidism and maple syrup urine diseases are hereditary diseases of the enzyme or hormone deficiency that we may have passed on to your child. Undetected and untreated, these diseases lead to early and permanent brain damage, physical deformities or death.
2. I have been informed that a blood test done on our baby after 24 hours can detect the presence of these diseases. If these diseases are detected within one month after birth, they can be successfully treated without permanent damage.
3. I have also been advised that the state- required supplemental newborn screening test for other genetic and metabolic diseases, which may be treatable, if identified early in life.
4. I acknowledge that I will speak with a pediatrician before delivery to discuss the PKU screening and implications for my newborn. This discussion will provide me with the necessary information to make an informed decision regarding the screening.

Initial the following

_____ We have discussed the newborn screen with our chosen pediatrician and we understand the risk if we object to the performance of the newborn screening test on our child. We assume all responsibility for this decision, and for any and all medical consequences that may result from it. We do not hold Maternity Options of Miami, LLC, midwives, all associates of "MOM" and their medical consultants in any way responsible for our decision to omit this testing.

_____	_____	_____
Client Printed Name	Signature	Date
_____	_____	_____
Other Parent Printed Name	Signature	Date
_____	_____	_____
Midwife Printed Name	Signature	Date