INFANT CARE CONSENT

While in hospital, I will be using the physician listed below as a personal physician to care for my infant.

_____

Print Physician Name

I understand that findings at the time of examination and discharge are inclusive only of the hospitalization.

I understand that I am responsible for obtaining appropriate continuing medical care for my infant, which includes making an appointment for a check-up for my infant, using a physician of my choice.

_____ _____

Motherôs Signature Date

_____ _____

Witness Date

HOSPITALIST SECTION

I presently do not have a personal physician that has privileges at St. John Medical Center for the initial examination or discharge of my infant.

I understand that a pediatrician on staff at hospital will care for my infant, for a fee, while in the hospital.

I understand that I am responsible for obtaining appropriate continuing medical care for my infant, which includes making an appointment for a check-up for my infant, using a physician of my choice.

I agree to have the physician on staff at hospital share information regarding the care of my infant with my pediatrician of choice.

_____ _____ _____

Physicianôs Name Office Phone Office Fax

_____ _____

Motherôs Signature Date

_____ _____

Witness Date