PEDIATRIC AGREEMENT FOR NEWBORN CARE

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Mother Name (PRINTED)

I intend to deliver my baby in the hospital and/or use the ñExpress Care,ò delivery option in the Family Suite. Either of these choices may result in a stay of 24 hours or less. I have completed the requirements of the Holistic Birthing Center and I am aware that I need a scheduled appointment for my infant to be seen by my pediatrician of choice within 72 hours of discharge or in the time frame specified by my pediatrician.

I am aware that certain medical conditions may require me and my infant to remain in the hospital for more than a 24 hour stay.

If there are any routine newborn medical treatments that I plan to refuse, I am aware that I need to discuss these decisions with my pediatrician prior to the birth of my infant. (Including but not limited to State of Ohio mandated administration of Vitamin K, Hepatitis B immunization and Erythromycin Eye Ointment and State of Ohio mandated testing such as Newborn Metabolic Screening (PKU) and Hearing Screening)

I am aware that if not completed in the hospital, follow-up Newborn Metabolic Screening (PKU) testing is my responsibility and I will have my infants test completed no later than 5 days of age.

I have established pediatric care for my newborn with ____________________________.

____ ________________________________
Motherôs Signature Date

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NEWBORN CAREGIVER

I am aware that the above parent has selected my practice for care of their newborn. I am aware that the patient may be opting for a post-partum short-stay of 24 hours or less. I have discussed the arrangements for medical care and the required newborn testing with the parents.

____ ________________________________
Physician Signature Date

Printed or stamped name ____