

LOVERS LANE BIRTH CENTER

GENERAL CONSENT FOR MATERNITY CARE

Being in approximately the \_\_\_\_\_ week of pregnancy and being \_\_\_\_\_ years of age, I hereby request enrollment in Lovers Lane Birth Center with the following understandings:

**I. Physical Examinations:**

I engage and authorize any member of the Midwifery Team Staff to perform physical examinations on my person to confirm general health and pregnancy status, obtain the usual specimens, and perform the usual diagnostic procedures, including but not limited to the following:

- A. Drawing blood for type and RH factor, serology, HIV, and other tests, including drug screen if indicated,
- B. Pregnancy test,
- C. Urinalysis, including drug screen if indicated,
- D. Blood pressure,
- E. Internal examination, including collection of both vaginal and cervical specimens, including a Pap smear.

It has been explained to my satisfaction that even when the above are properly and correctly done there is a potential for infection, tissue damage and other unpredictable medical conditions. I agree that the Midwifery Team Staff shall be responsible for the performance of their own professional acts only. The test results shall be the responsibility of those who perform them.

*Initials indicate acceptance:* \_\_\_\_\_

**II. Authority to Treat:**

I engage and authorize any member of the Midwifery Team Staff to treat, administer and provide as necessary or available to me and my baby:

- A. Healthcare, including parental education and instruction,
- B. Physical examinations are necessary,
- C. Obtaining of blood or other specimens for laboratory tests,
- D. Oral medications.
- E. Intramuscular, subcutaneous and intravenous injections and local anesthesia,
- F. Intravenous infusions,
- G. Delivery of my baby,
- H. Necessary episiotomy and repair,
- I. Postpartum care including family planning,
- J. In-home newborn care,
- K. A follow up home visit, and
- L. Such other procedures related to childbearing as may be deemed necessary

The administration and performance of such care may be at the office, the client's home, or elsewhere, including an ambulance. I grant full authority to the personnel of Lovers Lane Birth Center, its subcontractors and their personnel to administer and perform any and all drugs, treatments, tests, diagnostic procedures, examinations, and care to or upon me and my baby.

In case of emergency, I authorize any member of the Midwifery Team Staff to take

appropriate measures, and, when specialized equipment or hospitalization is believed required, to transfer me or my baby to a local hospital.

*Initials indicate acceptance:* \_\_\_\_\_

### **III. Early Transfer:**

I understand that if you recognize signs which indicate that the course of my pregnancy may deviate significantly from the normal (even though such deviate may not necessarily adversely affect the outcome of the pregnancy), you will discuss my condition with in terms of Lovers Lane Birth Center's criteria. Further, if after such discussion it is the decision of the Midwifery Team Staff that the management of my pregnancy shall be transferred to a physician and/or hospital, I/we agree to abide by this decision regarding transfer at any stage of the pregnancy.

*Initials indicate acceptance:* \_\_\_\_\_

### **IV. Informed Consent:**

While pregnancy and childbearing are normal human functions, it has been explained to me and I understand that there are hazards and stresses of childbearing. These maternal/neonatal hazards may arise or become aggravated suddenly and unpredictably. These include the poss of excessive blood loss, infection, convulsions, coma, allergic reaction and respiratory distress. The following are some other medical problems that could occur:

#### **affecting the mother:**

- placental abruption
- hemorrhage
- amniotic fluid embolism
- uterine rupture
- cardiac arrest
- anaphylactic shock
- amnionitis

#### **affecting the neonate:**

- umbilical cord prolapse and other cord accidents
- congenital anomalies
- fetal distress
- malpresentation
- maturity problems (pre- & post-)
- birth injuries
- stillbirth
- amnionitis

I understand that there are other newborn conditions such as hyperbilirubinemia, blood incompatibility, precipitous labor and respiratory distress syndrome, some congenital anomalies, allergies, and infections and brain damage (with or without mental retardation) that are difficult to recognize or are unrecognizable within 2-6 hours of birth.

I have been informed with regard to all of the foregoing and advised that I may have more detailed and complete explanations of each condition described and other even more remote risks, consequences, and conditions.

*Initials indication I do not desire further explanations at this time:* \_\_\_\_\_

I am aware that the practice of medicine, nursing and midwifery are not exact sciences and I acknowledge that no guarantees or assurances have been made to me concerning the results of my treatments, examinations, and procedures to be performed nor the outcome of my pregnancy.

*Initials indicate acceptance:* \_\_\_\_\_

**V. Client History and Right to Withdraw:**

In view of all of the above, I understand that in my acceptance and care by Lovers Lane Birth Center you will rely on my medical history and the information about myself which I provide. I affirm that such information is and will be correct and accurate to the best of my knowledge. In addition, I agree to follow all the rules, regulations, and policies of Lovers Lane Birth Center with the understanding that I may voluntarily withdraw from enrollment at any time I wish. If I choose to withdraw from enrollment, I will provide written notice.

*Initials indicate acceptance:* \_\_\_\_\_

**VI. Disposition of Specimens:**

Choose only one and indicate your choice by initialing.

\_\_\_\_\_ A. I hereby authorize Lovers Lane Birth Center to dispose of the placenta (after-birth.)

\_\_\_\_\_ B. I will be fully responsible for making other disposition arrangements for the placenta (after-birth). Failure to remove within 2 days after it is obtained will constitute approval of disposition under A.

**VII. Transfer Consent:**

I understand that in the event of a transfer, consulting physicians assume no responsibility or liability for events or management of labor that occurred prior to my arrival at the hospital.

I understand that in the event of a transfer to the hospital I am no longer considered a low risk pregnancy and I may require intervention. I agree to accept the treatment recommendation of the transferring physician which may include but is not limited to: intravenous fluids and medications, use of pitocin, electronic fetal monitoring, possible forceps or vacuum extraction, possible cesarean section.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Partner of Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_