



Midwifery Care Associates, P.C.
2 Tree Farm Road • Suite A110 • Pennington, NJ 08534 • 609.737.7512

POSTPARTUM AND NEWBORN PROCEDURES

Eye Prophylaxis

Antibiotic ointment is instilled into a baby's eyes to prevent blindness or eye infections caused by exposure to chlamydia or gonorrhea. This treatment is mandated by law in the State of New Jersey. If you decline this treatment for your baby, you must sign a waiver of care.

Vitamin K

Vitamin K, which is given to the baby by injection, increases the baby's blood clotting ability. Although only about one in 4,000 babies are born with clotting deficiencies, severe bleeding including intracranial hemorrhage and even death may result. A single dose of one mg. of natural, water-soluble Vitamin K injected soon after birth can eliminate the risk associated with clotting deficiency, as clotting factors rise two to three hours following administration. If you decline this treatment for your baby, you must sign a waiver of care.

Blood Glucose Test

Babies who are small or large for their gestational age, or who have been stressed during labor, may develop low blood glucose (hypoglycemia), which can be a cause of lethargy, poor feeding, and even respiratory and neurologic problems. The baby's blood glucose may be tested after the first hour of life to detect hypoglycemia.

Inborn Errors of Metabolism Screening

All babies born in New Jersey are required by law to be tested for fifty- four (54) disorders within 48 hours of birth. This sample will be obtained at the postpartum home visit, at no charge to you. You will be offered the option of supplemental screening for additional conditions at your own expense. Updated test descriptions and details appear at: <http://www.nj.gov/health/fhs/nbs/index.shtml>.

Hearing Screening

All babies born in New Jersey must have their hearing checked before leaving the hospital or before one month of age. A baby's hearing is usually checked within the first few days of life using one of two quick and painless screening methods; an Otoacoustic Emission (OAE) screening or an Auditory Brainstem Response (ABR) screening. Most hospitals will use only one

type of screening, but some hospitals use both. Both types of screening methods only take a few minutes to complete. Your pediatric caregiver will refer you to a center where screening can be performed to meet this requirement. More information: <http://www.nj.gov/health/fhs/ehdi/parentinfo.shtml>.

Postpartum Depression Screening

Postpartum depression affects one in every 8 to 10 women. It usually occurs within the first year after childbirth, miscarriage or stillbirth. The symptoms of PPD range from mild blues to severe depression. The exact cause of postpartum depression is unknown. Women of any age, race, or economic background may be at risk. Here are some factors that may contribute:

- Changes in hormone levels
- A difficult pregnancy
- A difficult birth
- Medical problems (mother or baby)
- Lack of sleep
- Feeling alone
- Loss of freedom
- Sudden changes in routines
- Personal or family history of depression
- Prior experience with PPD
- High levels of stress

PPD can affect any woman who:

- Is pregnant
- Has recently had a baby
- Has ended a pregnancy or miscarried
- Has stopped breast-feeding

At your postpartum visit, we will be giving you the Edinburgh Postnatal Depression Scale to read and fill out. The EPDS consists of ten short statements. The mother underlines the response closest to how she has been feeling during the past week, and most mothers complete the scale without difficulty in less than 5 minutes. When special follow-up is needed, we will help you locate counseling and other resources.

WAIVER OF CARE FOR NEWBORN PROCEDURES

I/we have thoroughly considered the merit and value of the recommended treatment(s) and/or test(s) for my/our newborn child. I/We acknowledge that we have received a full explanation of the proposed test(s) and or treatment(s), which I/we understand. Further I/we understand that the midwives of Midwifery Care Associates, PC do not condone our refuting of the test(s) and or treatment(s) specified below, nor do they assist us in refuting the mandates of the State of New Jersey or the Commonwealth of Pennsylvania.

I/We accept full responsibility for any consequences which may result from our refusal of the following test(s) and/or treatment(s) for my/our child.

_____	_____
_____	_____
_____	_____
_____	_____

Client

Partner

Child's Name

Child's Birthdate

RN/CNM