**Informed Consent Checklist**

I/We, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent(s) who have chosen to give birth with the assistance of Gena Reitano CPM, LM, have been fully informed orally and in writing regarding the following information and procedures. We have been informed and understand that in rare instances declining care could cause harm to mother and/or baby. We understand that if certain conditions or concerns arise during our care, we may be asked to have visits, tests, or procedures that we declined or that are not on this list. We knowingly choose to accept or decline the following visits, test, procedures, or medications.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ITEM | COST | | CHOICE | INITIALS | |
| WI Rules and Regulations | Given at initial prenatal | |  |  | |
| Experience and Training | Given at initial prenatal | |  |  | |
| Prenatal care in accordance with ACOG guidelines | Agreed upon at initial prenatal visit | |  |  | |
| 24 hr availability from hire to 6 week postpartum | Agreed upon at initial prenatal visit | |  |  | |
| Antenatal, labor, and postpartum care | | | | | |
| Routine Prenatal Visits | Included in Deposit: | | **Sliding scale $2300-$4500**  Amount we can pay:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Deposit must be paid in full by 37 weeks unless other arrangements are made ahead of time. |  | |
| Postpartum Visits | Included in Deposit:  3 home visits and 1 office visits | |  | |
| Birth Fee and Baby Craniosacral fascia work | Included in Deposit:  Must be paid by 37 weeks | |  | |
| Mother craniosacral Fascia Treatments | | **ADDITIONAL COST**  3 treatments for $250, additional treatments $100 each.  Must be scheduled ahead of time, and client must come to farm house. |  | |  |
| Newborn Care | | | | | |
| Newborn Vitamin K | Included in deposit | | * Yes * No |  | |
| Newborn Eye Ointment | Included in deposit  (required by state law, no exceptions. 253.11) | | * Yes * No |  | |
| Newborn Metabolic Screening | Included in deposit  (required by state law, exceptions based on religious beliefs or personal conviction. 253.13) | | * Yes * No |  | |
| Newborn Hearing Screening | Included in deposit  (required by state law, exception based on religious beliefs. 253.115) | | * Yes * No |  | |
| Critical Congenital Heart Defect Screen | Included in deposit | | * Yes * No |  | |
| Cord Blood Testing | **ADDITIONAL COST**  **$25** | | * Yes * Give Rhogam without testing |  | |
| Fetal Blood Screen | **ADDITIONAL COST** | | * Yes, if baby is Rh+ * No |  | |
| Circumcision | **BILLED SEPERATELY** | | * Yes * No |  | |
| **Additional tests and screens** | | | | | |
| Basic Prenatal panel  (required for first time clients) | **ADDITIONAL COST**  **$120** | | * Yes * No * Only if required |  | |
| Hemoglobin | Included in deposit | | * Yes * No |  | |
| Dipstick Urine analysis | Included in deposit | | * Yes * No |  | |
| Ultrasound | **BILLED SEPERATLY** | | * Yes * No * Only if required |  | |
| Urine Culture G/C  (required if signs and symptoms present) | **ADDITIONAL COST**  **$25** | | * Yes * Only if required |  | |
| Random Blood Sugar | Included in deposit | | * Yes * No |  | |
| Glucose Screening  (required if random is high or history of GDM) | **ADDITIONAL COST**  **gtt 2hr-$25**  **gtt 3 hr-$30** | | * Yes * No * Only if required |  | |
| GBS (required with previous ill babies at birth) | Included in deposit | | * Yes * No |  | |
| HIV Testing | **ADDITIONAL COST**  **$75** | | * Yes * No |  | |
| Cervical Cultures | **ADDITIONAL COST** | | * Yes * No |  | |
| Pap Smear | **ADDITIONAL COST**  **$50** | | * Yes * No |  | |
| Antibody Screen | **ADDTIONAL COST**  **$25** | | * Yes * No |  | |
| Rhogam | **ADDITIONAL COST**  **$160 per injection** | | * Yes * No |  | |

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Signature of parent Signature of parent

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Date