

NATIVITI WOMEN'S HEALTH & BIRTH CENTER

CONFIDENTIAL SELF-MEDICAL HISTORY

Please complete this form as accurately as you can. Please Print.

Name _____ Date of Birth _____ Age _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Race _____ Marital Status: M S D W

SS# _____ Employer _____ Phone _____

Spouse _____ Date of Birth _____ SS# _____

Employer _____ Phone _____ Type Work _____

INSURANCE INFORMATION

Primary Insurance _____ Insurance Phone _____

Insured Name _____ Policy # _____ Group # _____

Insurance Phone _____ Address _____

Secondary Insurance _____ Insurance Phone _____

Insured Name _____ Policy # _____ Group # _____

Insurance Phone _____ Address _____

Special Contact Instructions: _____

Emergency Contact _____ Relationship _____

Address _____ Phone _____

Reason for visit? _____ Referred by _____

MEDICAL HISTORY

Have YOU Ever Had?	FAMILY History? Who?			Have YOU Ever Had?	FAMILY History? Who?		
Rheumatic Fever	Yes	No		HIV/AIDS	Yes	No	
Lung Disease, Problems	Yes	No	Yes No _____	Thyroid Disorder	Yes	No	
Stomach Problems	Yes	No		Abnormal Pap Smear	Yes	No	
Heart Problems	Yes	No	Yes No _____	Sexually Transmitted Disease - HSV/ Chlamydia/Gonorrhea/Syphilis/HPV	Yes	No	
Kidney Disease	Yes	No	Yes No _____	Anemia	Yes	No	
Cancer	Yes	No	Yes No _____	Blood Transfusion	Yes	No	
Liver Disease	Yes	No	Yes No _____	High Blood Pressure	Yes	No	Yes No _____
Chronic Urinary Tract Infection	Yes	No		Twins	Yes	No	Yes No _____
Mental Disorder	Yes	No	Yes No _____	Breast Disease	Yes	No	Yes No _____
Post-Partum Depression	Yes	No		Diabetes	Yes	No	Yes No _____
Epilepsy	Yes	No	Yes No _____	Fetal Anomalies	Yes	No	Yes No _____
Hepatitis A B or C	Yes	No	Yes No _____	Other			
Drug/Alcohol Abuse	Yes	No	Yes No _____				

NATIVITI WOMEN'S HEALTH AND BIRTH CENTER, INC.
General Statement and Agreement
Informed Consent

PART I
TERMS OF ENROLLMENT

Nativiti Women's Health & Birth Center is designed to offer an alternative approach to normal, family centered childbearing. As an out-of-hospital center, it is a rather new type of facility in this area. While meeting the needs of many, it will not meet the needs of everyone. In order for you to make a decision about receiving your care during childbearing here at the Center, we want you to be fully informed about this alternative.

The care at the Center is provided by a Staff comprised of certified nurse-midwives and supporting caregivers which may include, but is not limited to, registered nurses, licensed vocational nurses, licensed midwives, midwife assistants and technicians, each practicing in accord with the expertise of their own discipline. The nurse-midwives may work in consultation with qualified physicians. A planned continuum of care has been established so that you will receive the care deemed most appropriate to your individual needs. When you register for care at the Center, you can expect to receive your prenatal, delivery, and postpartum care from a certified nurse-midwife and the birth center Staff so long as your status remains low risk. In some cases an obstetrician-gynecologist (or other consulting physician) may be consulted by the certified nurse-midwife as your needs indicate. Should problems arise that necessitate medical care, a physician will take over the management of your care.

We have made great effort to insure your safety, comfort and satisfaction. The Center has available the equipment, medication and other medical supplies we think necessary for normal childbearing in a homelike setting. **We are not, however, a hospital.** We do not have an operating room or intensive care unit for mother or baby, nor the highly specialized services and equipment which such units contain. Also, blood or blood fractions and general anesthesia are not administered here and the services of an anesthesiologist are not available. All of these are available at **St. Lukes Hospital, or Memorial Hermann Hospital, in the Woodlands, or Conroe Regional Medical Center** located a few miles from the Center. Nevertheless, some physicians and professional organizations have opposed this type of center because they feel there are certain inherent risks to mothers and babies not being delivered in hospitals. You should be aware that the practice of medicine, midwifery, and nursing are not exact sciences. By signing below, you acknowledge that no guarantees or assurances have been made to you concerning the results of the treatments, examinations and procedures to be performed, and release the Center and Staff from all liability for complications which may occur during the course of labor and delivery of your child as the result of your choice to use the Center.

If, in the judgment of your primary care provider there is a medical emergency, you will be transferred to **Memorial Hermann Hospital The Woodlands.** Every effort will be made for the nurse-midwife to accompany you to the hospital to support you. When possible, (1) our consulting physician(s), or (2) a prearranged physician of your choice will manage your care and conduct the delivery. When neither (1) or (2) are practical under the circumstances, you will receive care from the emergency on-call physician at the hospital. In the event transfer to a hospital is indicated but, in the judgment of your primary care provider, there is no emergency, transfer can be made to an area hospital and physician of your choosing. **All hospital and related expenses incurred at any time shall be your obligation.**

Normal postpartum care, including a home visit, will be provided by the Center. However, it is your obligation to select and arrange pediatric care for your baby. These arrangements should be made well before your due date and discussed with the nurse-midwife.

Because of the Center's philosophy of trust and honesty, all decisions concerning your health and the health of your baby will be discussed fully with you whenever possible. Do not hesitate at any time to ask any questions you have about the Center and its functions as well as anything that concerns you, your baby or your family.

Enrollment shall be at our exclusive discretion. Applicants will be notified of their acceptance only after

all records and the physical examination are completed and laboratory reports received.

Any complaint may be brought to the attention of the Director of the Center. A written statement of complaint may also be registered with the Director, Health Facility Licensure and Certification Division, Texas Department of Health, 1100 W. 49th Street, Austin, TX 78756, (800) 228-1570. Nativiti Women's Health & Birth Center will work to keep open lines of communication at all times in order to avoid a misunderstanding or grievance with our clients and their families.

The nature of the procedures listed, as well as the likelihood of other, unforeseen complications and treatment, have been explained to me to my satisfaction and no warranty or guarantee has been made as to the result of treatment given me or my infant by the Medical Team Staff whether in the Center or in any other hospital or facility related to care during my pregnancy, delivery and postpartum period. This contract, along with the "Informed Consent Part I" and "Consent Form - Part II" form the entirety of the representations made to me and form the entire contract between Nativiti Women's Health & Birth Center and myself regarding my care.

Notice: "Nativiti", "Center", or "Nativiti Women's Health & Birth Center" are references to a legal corporate entity registered and doing business in the State of Texas -- Nativiti Women's Health and Birth Center, Inc., Houston, Texas.

We, the undersigned, have read and understand the above "Terms of Enrollment" and have had the opportunity to ask questions. This agreement is entirely acceptable.

Patient's Printed Name

Mother's Signature

Date

Father's Signature

Date

Nativiti Women's Health and Birth Center, Inc.
Consent Form - Part II

I hereby request enrollment in the Nativiti Women's Health & Birth Center, Inc. (Center) program of care with the following understandings:

Note: "Medical Team", "Medical Staff", or "Staff" may include certified nurse-midwives, nurses, licensed midwives, midwife assistants, medical technicians and assistants employed by the Center, students in a program of study in the Center; non-employee associated consulting physicians, or other non-associated physicians, EMTs or hospital staff.

1. Physical Examinations: I engage and authorize any member of the medical team to perform according to the expertise of each discipline, 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 routine prenatal screening and other tests; (b) pregnancy tests; (3) urinalysis; (d) blood pressure; (e) internal examination, both vaginal and rectal with and without instruments; (f) obtain rectal, vaginal or 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 medical team shall be responsible for the performance of their own professional acts only, and the test results shall be the responsibility of those who perform them.

2. Authority to Treat: I engage and authorize any member of the medical team to treat, administer and provide as necessary or available to me and my baby, (a) health care including prenatal education and instruction, (b) physical examinations as 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) episiotomy and repair, (i) such other procedures related to childbearing as may be deemed necessary. The administration and performance of such care may be at the Center and elsewhere, including ambulance and hospital. I grant to the members of the medical team full authority to administer and perform all and singular, any drugs, treatments, tests, diagnostic procedures, examinations and ministrations to or upon me and my baby.

In case of emergencies, I authorize any member of the medical team to take appropriate measures, and when specialized equipment or hospitalization is believed required, to transfer me and/or my baby to a hospital.

All of the above is to be performed as deemed necessary or advisable by any member of the the medical team as the case may be, in the exercise of his or her professional judgment.

3. Early Transfer: I understand that you will, during the prenatal period, attempt to recognize "signs" which may indicate that the course of pregnancy of a particular woman might be significantly deviate from the normal, even though such deviation may not necessary affect the outcome. I will accept your decision to transfer me to a hospital where a consulting physician(s) of the Center, a physician arranged by me, or an on-call emergency physician will manage the mother's and/or baby's care.

4. Informed Consent: While the course of childbearing is a normal human function, it has been explained to me and I understand that in any particular case medical problems may arise unpredictably and suddenly which may be a hazard of childbearing or of being born, or may be aggravated by the stress of childbearing or of being born. There are the possibilities of excessive blood loss, infection, convulsions, coma, allergic reaction and respiratory distress. The following are some other medical problems affecting the mother that could occur:

placental abruption, toxemia, rupture of Circle of Willis aneurysm, amniotic fluid embolism, uterine rupture, cardiac arrest, anaphylactic shock, retained placenta, and placenta previa.

Some other medical problems affecting the fetus and newborn that could occur are:

prolapse and other problems relating to the umbilical cord, congenital anomalies, fetal distress, malpresentation, immaturity and post maturity, birth injuries, still birth, shoulder dystocia, and amnionitis.

I understand also that certain conditions affecting the newborn such as the effects of hyperbilirubinemia, blood incompatibility, precipitate labor and respiratory distress syndrome, some congenital anomalies, allergies, and infections and brain damage with or without mental retardation are difficult to recognize and are unrecognizable within 4 to 12 hours of birth (the time at which families normally will be discharged from the Center).

I have been informed with regard to all of the foregoing and advised that I may have more detailed and complete explanations than I have been given of each condition described and other even more remote risks, consequences and conditions. Please initial one of the following (failure to initial signifies choice (A)):

(A) I do not desire such further explanation (B) I do desire such further explanation

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 the treatments, examinations and procedures to be performed.

5. Personal History and Right to Withdraw: In view of all of the above, I understand that in the selection and treatment of mothers at the Center you will rely on my medical history and the information about me 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 the Center with the understanding that I may voluntarily withdraw from enrollment at any time I wish upon written notice to you.

6. No-Show Policy: Failure to keep scheduled appointments without written notice to the Center may constitute cause for dismissal. After 28 weeks, prenatal care is vital to the health of the mother and baby. Without this care, you will be in a high risk category which precludes your delivering in the Center.

7. Use of Medical Records: I understand that the Center is interested in researching the outcome of care through this program. I authorize the Center and such parties as are authorized by them to have full access to all my records for statistical studies and other research purposes. The only reservation is that my personal privacy be protected from the general public.

8. Disposition of Placenta: Please initial one of the following (failure to initial signifies choice (A)):

A. I hereby authorize the Center to preserve for scientific or teaching purposes or otherwise dispose of the placenta.

B. I will be fully responsible for making other disposition arrangements. Failure to remove within two days after it is obtained will constitute approval of disposition under (A).

9. I have **no** reservation to the use or administration to me or my baby when necessary of any medications or treatments referred to above, or any blood, blood fractions, or blood volume expanders.

10. We realize that this health service is also used for the purpose of teaching student nurse-midwives and other certified nurse-midwives and related medical professionals. We give permission for these persons to observe and/or take part in our care under the supervision of the certified nurse-midwife and/or physician.

11. I understand that the Center maintains certain liability insurance policies and that, upon request, these policies will be shown to me.

12. Affirmation: I have inspected the Center and have attended an orientation session(s) conducted by the staff. I have read all of the above thoroughly and carefully. I understand all that I have read after careful study and discussion. This agreement is entirely acceptable.

The nature of the procedures listed, as well as the likelihood of other, unforeseen complications and treatment, have been explained to me to my satisfaction and no warranty or guarantee has been made as to the result of treatment given me or my infant by the medical team staff whether in the Center or in any other hospital or facility related to care during my pregnancy, delivery and postpartum period. **This contract, along with the "Informed Consent Part I" and "Consent Form - Part II" form the entirety of the representations made to me and form the entire contract between Nativiti Women's Health & Birth Center, Inc. and myself regarding my care.**

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Printed Name of Mother _____

Signature of Mother _____

Date Signed _____

Signature of Father _____

Date Signed _____

Witnessing Staff Member _____

Date Signed _____

NATIVITI WOMEN'S HEALTH AND BIRTH CENTER, INC
Consent for Examination, Treatment and Release of Records,
Prenatal, Birth, Newborn and Well Woman Care

Name: _____ Phone: _____

DOB: _____ SS# _____

Address: _____

I authorize and direct the staff of Nativiti Women's Health & Birth Center to examine me and perform those procedures necessary for prenatal and/or family planning care and/or women's health care, and child health care. Procedures that may be performed include, but are not limited to:

Medical history and physical examination, including pelvic and breast examination
Spontaneous vaginal delivery of low risk women, including any necessary procedures
Blood work to screen for syphilis, anemia, rubella, diabetes, hepatitis, HIV
Urinalysis, urine culture and drug screen
Gonorrhea/Chlamydia culture and Pap smear
Neonatal screening/newborn exam, circumcision (if desired)
External fetal monitoring or limited ultrasound as needed
Other appropriate lab work

I understand that my care and examinations will be provided the Medical Team Staff, primarily comprised of Certified Nurse-Midwives, but also including consulting physician(s), independent non-associated physicians, or members of the Nativiti Women's Health & Birth Center staff including, but not limited to RN's, licensed midwives, midwife assistants, student nurse-midwives or nursing students.

I authorize release of any information required for payment of charges for services rendered by Nativiti Women's Health & Birth Center. I further authorize release of information to any hospital or medical facility I present myself to for medical care. I understand that I am responsible for all charges associated with services provided by the Center and its staff, including any balance not paid by third party payers. I understand that failure to make payment by the scheduled payments date may be ground for dismissal from care at the discretion of the director of the Center.

The nature of the procedures listed, as well as the likelihood of other, unforeseen complications and treatment, have been explained to me to my satisfaction and no warranty or guarantee has been made as to the result of treatment given me or my infant by the Medical Team Staff whether in the Center or in any other hospital or facility related to care during my pregnancy, delivery and postpartum period. This contract, along with the "Informed Consent Part I" and "Consent Form - Part II" form the entirety of the representations made to me and form the entire contract between Nativiti Women's Health & Birth Center and myself regarding my care.

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Patient's Signature: _____ Date: _____

Cystic Fibrosis Informed Consent (8-12 wk visit)

I understand that the decision to test for Cystic Fibrosis carrier status is completely mine; I also understand that the test does not detect all carriers. I understand that if I am a carrier, testing the baby's father will help me learn more about my baby's chances for acquiring Cystic Fibrosis. I further understand that if one parent is a carrier and the other is not, it is still possible my baby will have Cystic Fibrosis, but the chance is very small. I understand that if both parents are carriers, additional testing can be done in order to determine whether or not the baby will have Cystic Fibrosis. The chances of this are 1 in 4 if both parents are carriers.

_____ Accept testing

_____ Decline testing

Ultrascreen 1st Trimester Down's syndrome screening (11-13+wk visit)

We are required by law to offer you a Down's syndrome screening. The test we offer is called the Ultrascreen. This consent verifies that you have received the information regarding the Ultrascreen and had the opportunity to ask questions. You understand that the Ultrascreen must be performed between 11 weeks 1 day to 13 weeks 6 days. You also understand the Ultrascreen involves ultrasound to view baby's nuchal translucency (NT), the area behind the baby's neck, combined with a blood sample from the mom's finger tip. This test is 91% effective in detection of Down's syndrome and 98% of Trisomy 18 pregnancies. A normal screen does not guarantee a normal pregnancy outcome. If this test were to come back positive, more testing will be required.

_____ Accept testing

_____ Decline testing

Alpha Fetoprotein -AFP- (16-20 wk visit)

I understand that this is also an optional blood test that is done in the second trimester between 16-20 weeks. This test is a screening that will test for possible Neural Tube Defects. This test is usually done to complete the Ultrascreen 1st Trimester Screening or if you would like to have screening for possible genetic defects. Should the test come back positive, more testing will be required to obtain more information on your risk of carrying a baby with a genetic defect. It is also noted that this test has a high level of false positives and many women who test positive still go on to deliver healthy babies.

_____ Accept testing

_____ Decline testing

Cord Blood Banking Informed Consent (28 wk visit)

I have Received and read information related to cord blood banking. I have had the opportunity to ask questions and have had those answered to my satisfaction. I acknowledge that should I decide to collect cord blood for storage, I am responsible to make the arrangements for collecting the blood by selecting a company as well as payment for the storage of blood. I have also been given the choice that I may decide to donate the cord blood cells if I do not wish to store my baby's cord blood. If I wish to donate, I am responsible for finding a company that accepts cord blood donations.

_____ Accept cord blood banking

_____ Decline cord blood banking

HIV, Syphilis, and Hepatitis B Testing (8-12 wk visit; repeat during 3rd Trimester)

The Texas Department of State Health Services have recently passed a new law starting January 1,2010, that all pregnant women must be tested and educated about HIV, Syphilis, and Hepatitis B during her 1st trimester and repeated during the 3rd trimester. If repeated testing from 3rd trimester is not documented in the chart prior to delivery of infant, the mother and baby must be tested at time of delivery unless you objected to repeating this lab work.

_____ Accept 3rd Trimester HIV, Hepatitis B, and Syphilis

_____ Decline 3rd Trimester HIV, Hepatitis B, and Syphilis

Signature

Printed Name

Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

NATIVITI WOMEN'S HEALTH AND BIRTH CENTER

ACKNOWLEDGEMENT FORM:

I have received the Notice of Privacy Practices and/or I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____ Date _____

_____ (Initial) I hereby refuse to acknowledge receipt of the Notice of Privacy Practices and refuse to read or acknowledge any of the terms and conditions thereof. I understand that even though I may refuse to sign this acknowledgement, Nativiti Women's Health and Birth Center may still provide treatment.

Signature _____ Date _____

For Office Use Only

I, _____ acting as the staff representative for Nativiti Women's Health and Birth Center attempted to obtain the written acknowledgement of receipt of the Notice of Privacy Practices on _____ (date attempt was made), but acknowledgement could not be obtained because:

_____ (Initial) Patient or Patient's legal representative refused to sign.

_____ (Initial) Patient or Patient's legal representative could not be communicated with sufficiently to obtain acknowledgement.

_____ (Initial) Emergencies circumstances prevented securing acknowledgement.

_____ (Initial) Other _____

Signature of Representative _____ Date _____

NATIVITI WOMEN'S HEALTH & BIRTH CENTER

GLOSSARY OF TERMS

This list of terms has been compiled to assist in completely understanding all the medical terms used in the General Statement and Agreement.

AMNIONITIS: Inflammation of amniotic membrane usually due to infection and associated with prolonged rupture of membranes (more than 24 hours before birth). This condition may be dangerous to both mother and baby.

AMNIOTIC FLUID EMBOLISM: A rare condition caused by entry of amniotic fluid or material into the mother's bloodstream at the placental site and resulting in respiratory distress and shock which can be fatal.

ANAPHYLACTIC SHOCK: Severe allergic reaction due to hypersensitivity to medications or proteins, i.e. penicillin. Can be fatal.

CARDIAC ARREST: Sudden, unexpected cessation of the heartbeat and circulation. Could result from extreme blood loss, shock, severe heart condition, allergy or overdose of drugs, or other severe medical complication.

CERTIFIED NURSE-MIDWIFE (CNM): A CNM IS AN INDIVIDUAL EDUCATED IN THE TWO DISCIPLINES OF NURSING AND MIDWIFERY, WHO POSSESSES EVIDENCE OF CERTIFICATION ACCORDING TO THE REQUIREMENTS OF THE American College of Nurse-Midwives. Nurse-midwifery practice is the independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally and/or gynecologically, occurring within a health care system which provides for medical consultation, collaborative management, or referral and is in accord with the Functions, Standards, and Qualifications for Nurse-Midwifery Practice as defined by the American College of Nurse-Midwives.

The nurse-midwife provides care for the normal mother during pregnancy and stays with her during labor providing continuous physical and emotional support. She evaluates progress and manages the labor and delivery. She evaluates and provides immediate care for the normal newborn. She helps the mother to care for herself and for her infant; to adjust the home situation to the new child; and to lay a healthful foundation for future pregnancies through family planning and gynecological services. The nurse-midwife is prepared to teach, interpret and provide support as an integral part of her service.

COMA: A state of prolonged unconsciousness due to some disease or injury.

CONGENITAL ANOMALIES: Developmental defects such as cleft lip, club foot, extra finger, etc. Anomalies may be incompatible with life.

CONVULSIONS: Episodes of involuntary muscular contractions and relaxations due to a variety of causes.

EPISIOTOMY: An incision made into the perineum to temporarily enlarge vaginal opening at time of delivery of the baby. Such an incision requires repair by suture.

FAMILY-CENTERED CARE: Care which has as its central focus the needs and desires of the mother and those persons she considers her family. It is always directed toward strengthening the family's inner resources so that all may be better able to participate in the pregnancy and birth experience and to experience deep and enduring satisfaction which may be reflected in the parenting of the child.

FETAL DISTRESS: Significant drop in baby's heart rate and/or irregularity of the heart rate usually coupled with staining of the amniotic fluid with stool indicating that the fetus is being deprived of adequate oxygen supply.

GENERAL ANESTHESIA: Complete loss of sensation with loss of consciousness when the anesthetic acts on the brain. This type of anesthesia is usually accomplished following administration of inhalation or intravenous anesthetic. Commonly used for surgical procedures; may be used for Cesarean section.

HYPERBILIRUBINEMIA: (Jaundice) Excessive bilirubin (pigment) in the blood resulting in yellowing of the skin and whites of the eyes. Bilirubin is usually broken down and excreted in urine and stool. The newborn is lacking the enzyme necessary for this breakdown and therefore bilirubin may build up in the bloodstream. Jaundice is normal in many newborns. Excessive jaundice, however, may be caused by blood incompatibility, infection, or liver malfunctions and requires treatment to prevent possible brain damage to the newborn.

IMMATURITY: The condition of being born at a point of development incompatible with life outside the uterus without supportive measures. Usually prior to 37 weeks of pregnancy.

INTRAMUSCULAR INJECTION: Medication given into a muscle with a needle and syringe.

INTRAVENOUS INJECTION: Medication given into a vein through a needle. The medication can be given full strength in a short time or diluted in sterile fluids and given over an extended time.

LOCAL ANESTHESIA: Injection of a preparation such as Novocain to cause loss of sensation (numbness) in a body area.

MALPRESENTATION: Any part of the baby other than the vertex (top of the baby's head) or the buttocks (breech) which enters the pelvis first, i.e. face or shoulder. (Note: Breech cannot be delivered at the Center.)

PAP SMEAR: Screening test for cancer of the cervix. The mouth of the womb is lightly scraped with a wooden spatula to obtain cells for microscopic examination.

PLACENTAL ABRUPTION: Separation of the placenta (partial or complete) from the wall of the uterus before the birth of the baby, therefore cutting off the blood supply to the baby. Abruption can occur before or during labor and is usually associated with complications of pregnancy such as high blood pressure or severe trauma and requires immediate cesarean birth if separation is significant enough to cause fetal distress.

PLACENTA PREVIA: Placenta which is implanted low in the uterus and either partially or totally covering the internal opening of the uterus (internal cervical os). Such a condition may cause bleeding from the placenta which may be life-threatening to the baby.

POSTMATURITY: Failure of the placenta to function optimally when pregnancy has continued well past the due date, usually beyond 42 weeks. May result in fetal distress or baby showing characteristics of nutrition deprivation.

PRECIPITATE LABOR: Labor and delivery lasting less than three hours, often associated with tumultuous contractions, either spontaneous or induced. Such labor may cause trauma to baby as it cannot so rapidly adapt to the process of being born.

PROLAPSE OF THE CORD: Expulsion of the umbilical cord into the vagina with rupture of the membranes due to the presenting fetal part not being firmly fixed in the pelvis. Compression of the cord by the descent of the baby cuts off blood supply to the baby causing fetal distress and possible death if not diagnosed and treated immediately.

RESPIRATORY DISTRESS SYNDROME: Breathing difficulty in the early hours or days after birth due to incomplete lung development. Usually present in immature babies, it requires careful monitoring and treatment of the baby.

RETAINED PLACENTA: Placenta which is not able to be expelled spontaneously following the birth of the baby.

R. H. FACTOR: An antigen (protein substance) which in 85% of the population is present in the blood (RH positive). In 15% it is absent (RH negative). If the RH NEGATIVE EXPECTANT MOTHER RECEIVES OR HAS RECEIVED IN THE PAST RH positive antigen, antibodies may form in the blood. These do not affect the mother, but may cause a harmful blood incompatibility if the baby she carries has RH positive blood.

RHOGAM: A medication administered to RH negative mothers at 28 weeks and after giving birth to an RH positive baby, to prevent development of antibodies in the mother which could affect future pregnancies.

RUPTURE OF CIRCLE OF WILLIS ANEURYSM: CIRCLE of WILLIS ANEURYSM refers to a congenital ballooning of an artery at the base of the brain. This is a very rare condition and not caused by pregnancy. Aneurysm may rupture at any time due to stress and is usually only diagnosed after this has occurred. Usually is fatal.

SEROLOGY: Blood test used to screen for the presence of syphilis, a venereal disease which if untreated can be harmful to the unborn infant and mother.

SHOULDER DYSTOCIA: Difficult delivery caused by large size of an infant's shoulders in relation to the mother's pelvis. Shoulder dystocia is associated with maternal obesity, oversized infants and maternal diabetes.

SUBCUTANEOUS INJECTION: Medication given beneath the skin with a needle and syringe.

TOXEMIA (PRE-ECLAMPSIA): A condition related to late pregnancy, usually first pregnancies, where a variety of body systems react negatively to the pregnancy. Clinical symptoms may include high blood pressure, significant swelling generally, spilling of protein in the urine, and/or hypersensitive reflexes. This condition may be very mild to very severe leading to convulsions (eclampsia).

UTERINE RUPTURE: Tearing of the wall of the uterus. Usually associated with previous uterine surgery, trauma to the uterus, or extremely prolonged or poorly managed labor.