

Overlook Medical Center Maternity Pre-Admission Packet



Atlantic
Health System

Overlook Medical Center

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Welcome to the Maternity Center
at Overlook Medical Center

Dear Mom to Be,

We would like to take a moment to congratulate you and your family and to thank you for choosing Overlook Medical Center to assist you during this special time. In the pages that follow you will find information essential to your delivery and your stay at the hospital, as well as answers to many questions you may have.

Overlook Medical Center takes pride in its efforts to provide the most up to date, evidence-based quality care. We provide a family-oriented environment, staffed by caring medical professionals and have proven our ability to provide safe care for any type of delivery; from the lowest risk birth to caring for sick moms and their babies. Our facility has both a labor hospitalist and an anesthesiologist in the department 24/7 to care for you and your baby.

You may have already heard we redefined and redesigned our model of care. We believe that the best way to care for the mom and baby as a couplet is to provide that care in the mother's room by the same nurse. Evidence shows minimizing separation between mother and baby helps promote bonding and provides a smooth transition from hospital to home. You will not be alone – your nurse will be right there to take care of both you and your baby.

We have received Baby Friendly designation and have enclosed some literature regarding that designation. We believe that all mothers should be treated with respect and support regardless of their feeding choices.

While you are here, expect to enjoy our private patient rooms, a relaxing complimentary massage and a celebratory dinner for you and your loved one. Expect your recovery time to be up to 48 hours for a vaginal delivery and three nights for a cesarean section.

We wish you and your family a wonderful and memorable delivery. We look forward to becoming part of your families' memories.

Sincerely,

The Maternity Center at
Overlook Medical Center

Delivering at Overlook Medical Center

Overlook Medical Center is proud to have received Baby Friendly designation. Your obstetrician and pediatrician along with Overlook Medical Center work together to provide an environment that supports bonding and breastfeeding. You will have ongoing contact with your baby right from delivery and will get the support and help you need to breastfeed successfully.

The Baby Friendly Hospital Initiative was started by UNICEF to help health care providers give patients the best care and to help support mothers in feeding and caring for their babies. To be considered Baby Friendly, the hospital must meet the best practice standards in supporting breastfeeding. At Overlook Medical Center:

- › **We believe that breastfeeding** provides many benefits for mothers and babies and we recommend exclusive breastfeeding for the first six months of life, then continued breastfeeding with the introduction of solids. Babies who receive breast milk have less risk of food allergies, diarrhea, ear infections, obesity, diabetes and SIDS (Sudden Infant Death Syndrome). Mothers who breastfeed have less risk of postpartum hemorrhage, osteoporosis, breast cancer, ovarian cancer and Type II Diabetes.
- › **We believe that all babies should feed on demand**, regardless of infant feeding choice.
- › Look for your baby's early signs of hunger such as rooting, licking lips, or putting his hands to his mouth. This is when your baby should be offered a feeding. Do not wait until your baby is crying – this is a late sign of hunger. Babies will usually demand to eat 8 or more times in 24 hours. Don't put time constraints on when or how long your baby can eat. Let your baby nurse for as long and as often as he or she wants. The more often a baby nurses – the more milk you will make. Most babies are more hungry at night. This is when a woman will produce the most breast milk.
- › **We believe that breastfeeding babies should avoid pacifiers and artificial nipples** in the first 3-4

weeks of life until breastfeeding is well established. During this time, pacifiers should only be used for comfort during painful procedures. Early pacifier use can mask signs that your baby is hungry, decrease the number of feedings your baby gets, contribute to a painful latch, and decrease your milk supply. For these reasons we will not provide pacifiers in the well-baby nursery. If you plan to both breastfeed and formula feed, we recommend that you start only breastfeeding, then add formula after 3-4 weeks. After breastfeeding has been established, the American Academy of Pediatrics recommends that your baby should be offered a pacifier at nap and bed time to reduce the risk of Sudden Infant Death (SIDS).

- › **We believe that all mothers should be treated with respect** regardless of infant feeding choice. A mother's infant feeding choice will be explored and education will be offered, but a mother's final choice will be respected and supported.
- › **We believe that early and frequent skin to skin contact** between mom and baby is beneficial to both the mother and the baby. Skin to skin contact is when your naked or diapered baby is placed on your bare chest and you both are covered with a blanket. This should be done as soon after delivery as possible. This close skin to skin contact helps your baby warm, decreases crying, and helps with the adjustment to life outside the womb. Skin to skin contact also helps breastfeeding. Skin to skin contact helps new mothers remain calm, lowers blood pressure and stabilizes heart rate and breathing.
- › **We believe that Rooming In** increases rest for both mom and baby no matter how you have decided to feed your baby. Staying together helps a mom to learn her baby's feeding cues and special needs. Most routine care can be done right in your room. Moms who keep their babies with them make more breast milk faster. Research shows that moms who keep their babies in the room with them actually sleep more than moms who send their babies back to the nursery. Babies who stay with their moms sleep longer and cry less than babies who are sent back to the nursery. But don't worry! You won't be on your own – your nurse will be there to take care of both you and your baby.

Keys to Successful Breastfeeding

- › **Learn about breastfeeding**, read, attend a breastfeeding class, speak to your health care provider, attend a mother's breastfeeding support group such as laleche league and talk to other moms who have successfully breastfed their babies. At Overlook Medical Center we offer free breastfeeding support groups.
- › **Think about what you plan to use for pain relief in labor.** Some medications can make a baby very sleepy and not interested in breastfeeding at first. Consider non-pharmacologic (non-medicine) methods to help labor pain. Take a prepared childbirth class to learn about your choices. Walking, rocking or using a birthing ball in labor can be helpful. Others use relaxation, breathing exercises, or meditation. It is mom's choice how she chooses to manage her pain.
- › **Your baby will be most interested in starting to breastfeed in the first one-to-two hours of life.** Your baby should be placed skin-to-skin with his/her ear over your heart, tummy to tummy and covered with a blanket. You can keep baby warm and it's the perfect place to help baby adjust to life outside of the uterus. Most babies will root and seek the breast and latch onto the breast with just a little help.
- › **Look for early signs that your baby is hungry,** baby may put hands to mouth, lick, root or make smacking sounds or turn head toward your breast. That is the best time to start feeding. Don't wait until baby is crying your baby may be too fussy or tired to eat. Find a comfortable position that works for you and your baby. Use pillows for support.

Here are some position ideas:



Cradle Hold



Cross Cradle Hold



Side Lying



Football Hold



Reclining

- › **Help your baby latch on.** Position your baby tummy to tummy so there are no gaps between you and your baby. The baby's nose should be opposite your nipple with head slightly tilted back. Stroke the baby's lips with your nipple.



Wait until baby opens the mouth **WIDE** and then assist the baby deeply onto your breast. The baby's lower lip should catch the bottom areola first; then the nipple and areola follow.

- › Let your baby decide how often to eat. Let your baby nurse until satisfied – there is no time limit. Your baby should eat 8–12 times in 24 hours. In order to increase your milk supply your baby may cluster feed (Short frequent feeds every hour or so). This often happens during the first few nights because that is when your body makes the most milk. Baby will also cluster feed during a growth spurt.
- › At first your baby receives your colostrum, then in 72 hours your breasts will get heavy and fill with milk. You will hear more swallows and the baby will make more diapers.

Rooming-In Around the Clock

Best For The Whole Family

BETTER FAMILY TIME

- › Rooming-in is best for all mothers and newborns - No matter how you plan to feed your baby!
- › It helps you and your family to learn the baby's cues for eating and helps with bonding.
- › Gives you more chances to be skin-to-skin with your baby.
- › Gives you more confidence in caring for your baby.
- › Procedures such as baths, weighing, and examinations of the infant can be done in your room and this will give you a chance to learn even more about your baby.
- › We will be visiting you often and will be helping you care for your baby.
- › If you have a cesarean, it may help to have someone with you during your hospital stay. This way, while you're recovering you'll still have the benefits of rooming in and spending time together.

BETTER SLEEP

- › A lot of people think that a mother will get more rest when the baby is in the nursery, but that's not actually true.
- › Babies who room-in with their mothers sleep deeper and longer.
- › Babies who stay with their mothers cry less
- › Mothers sleep better when babies room-in with them.

BETTER EATING

- › You make more milk at night than at any other time of the day and your baby is hungriest at night!
- › Keeping your baby with you at night will build your milk supply faster so that you have enough milk to satisfy your baby at night.
- › Babies who room-in breastfeed more frequently therefore gain more weight and decrease the chance of jaundice.
- › Breastfeeding babies that room in with mom are less likely to be supplemented with formula.





Pitfalls of Pacifiers

Pacifier use, especially during the first two-three weeks, may have many unanticipated consequences.

Some of these are:

- › Pacifiers can satisfy a baby's natural urge to suck and could therefore decrease the time spent at the breast. Sometimes babies are able to soothe themselves to sleep with a pacifier without having eaten enough. Regular pacifier use can contribute to poor weight gain, in the first few weeks of life.
- › A decrease in breast stimulation and milk removal may delay the mother's milk "coming in" and lead to long-term low milk supply. Research correlates a strong link between pacifier use and early weaning.
- › Babies suckle differently on a pacifier than on a breast. The pacifier's shape lends itself easily to a pursed lip and a tight jaw posture. When a baby attempts to suckle in this fashion on the breast, the latch is shallow and painful with a biting action. This is an ineffective, painful latch, with poor or no milk transfer.
- › Pacifier use may contribute to thrush infections. The surface of a pacifier is irregular and porous and when combined with moisture and room temperatures, creates a medium for yeast growth.
- › For these reasons, we will not provide pacifiers in the newborn nursery. If you would like your baby to have a pacifier, please bring one of your own choosing.
- › After breastfeeding has been established, the American Academy of Pediatrics recommends that your baby should be offered a pacifier at nap and bed time to reduce the risk of Sudden Infant Death (SIDS).

FYI

› Your Baby's Cord Blood:

-Please read over the Your Baby's Cord Blood section for more information on banking your newborn's cord blood. Please have all arrangements made prior to your admission to Labor and Delivery. When you come to the hospital, you will be asked about your plans for the cord blood.

› HIV Testing in Pregnancy:

- Human Immunodeficiency virus is the virus that causes AIDS. HIV virus can be passed from mother to baby during pregnancy, at delivery and through breastfeeding.
- If a pregnant woman refused testing during the third trimester of her pregnancy, her newborn baby will be tested for HIV infection within a few hours after birth.
- For more information on HIV Testing in Pregnancy please read: HIV Testing in Pregnancy It's the Law.

› Your Baby's Pediatrician:

- Prior to your admission you must choose a pediatrician in your insurance plan.
- You will be asked who your pediatrician is upon admission and be required to provide the address and phone number.
- We have provided a Newborn Provider Worksheet so the information can be readily available when you come to the hospital. (PROVIDE THIS INFORMATION UPON ADMISSION FOR YOUR DELIVERY)
- We do have Hospitalists (hospital-based physicians) on staff for your baby if your Pediatrician does not have privileges with our hospital.
- If you will be using our Hospitalist staff we still need your pediatrician information.

› Newborn Care Information:

- During your newborns stay he/she will have a number of preventive testing and procedures that are routinely performed.
- Please review this information so you are aware of what to expect regarding the care of your newborn.
- Car seats are required for all children. For more information on safety seats, go to the American Academy of Pediatrics: **healthychildren.org**

If you have questions or need help installing your car seat, find a CPS technician. A list of CPS technicians is available by state or zip code at: **http://cert.safekids.org**. For a list of inspection stations where you can go to learn how to correctly install a car safety go to: **seatcheck.org** or call the NHTSA at 888-327-4236.

In Northern NJ go to **preventionworks-nj.org/car-seat-inspection.php** for list of inspection sites and schedule.

› Tours:

- You can arrange a tour of our maternity center by calling 1-800-247-9580 or by registering online at <http://landing-pages.atlantichealth.org/calendar/>



› **Birth Certificate Worksheet:**

- Included for your convenience and can be completed prior to your admission for delivery.
- Please give worksheet to the secretary upon admission.
- Name can be left blank; the Birth Clerk will meet with you prior to your discharge to complete any missing information.
- At that time you will be asked to proofread the birth certificate for accuracy.

› **Postpartum Depression**

- We screen for depression during your pregnancy and while you are here at the hospital. There are resources available to all women for treatment and support. You may call the Atlantic Behavioral Health Access Center at 888-247-1400 for guidance, support groups and referrals to professionals

Your Baby's Cord Blood

Congratulations on your pregnancy! This is a time of excitement, changes, learning and decision-making. There is so much information and many choices to consider as you approach the birth of your baby.

One option you have to consider before your baby's birth, is what to do with your baby's cord blood. Cord blood is the unused blood, which is left in the baby's umbilical cord and placenta after the baby is born. This blood is rich in stem cells, which can be collected, frozen and stored. Like bone marrow, stem cells from cord blood may be used later to treat your baby, other family members, or other person for a growing number of diseases, including cancer, leukemia, lymphoma, some forms of anemia, sickle cell disease and severe combined immune deficiency.

If you decide to save the cord blood:

At least **4 WEEKS BEFORE DELIVERY**

1. Choose a cord blood company. Some are listed below. You must make arrangements before coming into the hospital to have your baby. There is a processing fee and storage fee that must be paid every year. The actual cost will vary by company.
2. Please complete all paperwork before coming to the hospital.
3. When you come to the hospital, you will be asked if you have arranged for a cord blood collection. Please keep track of the kit, as you will need to contact the company once you have delivered and have the completed cord blood kit.
4. Donations:
There is a cost to privately bank cord blood therefore, donations may be an option to you. Your physician may still charge a fee, even if you donate. Call the following companies to see if they are currently accepting donations.

For More Information About Saving Your Baby's Cord Blood

Websites:

cordblooddonor.org

bethematch.org

parentsguidecordblood.com

Cord Blood Banks:

Cord Blood Registry (private)
Phone: 1-888-932-6568

Cryo-Cell (private)
Phone: 1-800-786-7235

Lifebank (private)
Phone: 1-877-543-3226

Viacord (private)
Phone: 1-866-668-4895

The following forms need to be completed and sent back to the hospital by mail, email, scan or fax. This will make your admission process more efficient.

- REGISTRATION PAGE
- COPY OF ID AND INSURANCE CARD
- NEWBORN PROVIDER PAGE
- ROUTINE NEWBORN CARE PAGE
- DELIVERY ROOM PHOTOGRAPHER PERMIT
- SIGNED SUPPLEMENTAL SCREEN ACKNOWLEDGEMENT
- ADVANCE DIRECTIVE (OPTIONAL)
- BIRTH CERTIFICATE WORKSHEET (OPTIONAL)

Please send all correspondence to our registrar

gina.natale@atlanticealth.org

fax 908-522-5383



MATERNITY REGISTRATION INFORMATION

Please have Photo ID and Insurance cards available

Email Address: _____ **Obstetrician's Name:** _____

Due Date: _____

Primary Care Doctor: _____

Patient Information

Patient Name: (Last, First, & MI)		Maiden name:	Sex: F M
Birthdate:	Social Security #:		Marital status: S W D M
Mailing Address:			Apt #:
City:		State/Zip Code:	
County:		Preferred Phone #:	
Race:	Nationality:	Can we leave a phone message?	
Religion (optional):		Do you want a confidential address/phone?	
Faith Community/Congregation (optional):		Allergies:	
Do you have a living will? No Yes		If yes, please enclose a copy.	Preferred Language:

Alternate / Confidential Address

Resident Type:	College	Boarding school	Relative's home	Friend's home	Shelter
Address:					
City, State, & Zip code:			Can we mail to address?		
Phone #:			Can we leave a phone message?		

Patient's Employer Information

Are you employed:	Not Employed	Full time	Pt time	Student	Self employed	Military
Employer/school name:			Patient Occupation:			
Employer Address:			Work Phone #:			
City:			State/Zip Code:			

Significant Other / Spouse's Information

Name: (Last, First, & MI)			Relation to Patient:			
Birthdate:	Social Security #:					
Mailing Address:			Preferred Phone #:			
City:			State/Zip Code:			
Employment Status:	Not Employed	Full time	Pt time	Student	Self employed	Military
Employer:			Occupation:			
Mailing Address:			Work Phone #:			
City:			State/Zip Code:			

Notification in Case of Emergency (A second person to contact if desired)

Please notify: (Name)			Relation to Patient:			
Address:			City, State, & Zip code:			
Home Phone #:			Work Phone #:			

Due to the multitude of variations with Insurance plans we cannot be responsible for knowing each individual patient's coverage plan. Therefore make sure that you familiarize yourself with your insurance plan, and keep us updated with any changes. If information is not received, incomplete, or inadequate we will have to register you as a "Self Pay Patient". This means you will be getting the bill from the hospital and will then have to submit the bill to your insurance company.

Primary Insurance Information			
Name of Insurance Company:		Insurance Plan:	
Policy #:	Group #:	Relation to Insured:	Patient Relative
Address:		Phone #:	
City, State, & Zip code:			
Secondary Insurance Information			
Name of Insurance Company:		Insurance Plan:	
Policy #:	Group #:	Relation to Insured:	Patient Relative
Address:		Phone #:	
City, State, & Zip code:			



HIV TESTING IN PREGNANCY

It's the Law

What is HIV?

HIV, human immunodeficiency virus, is the virus that causes AIDS. HIV is a serious illness that weakens the immune system which is how your body fights against disease. HIV is spread through body fluids such as blood, vaginal fluid, breast milk, and semen. It can be spread by having sex without a condom or by sharing needles with a person who has HIV.

HIV virus can be passed from a mother to her baby.

Why is HIV Testing important for Pregnant Women?

- HIV can be passed from a mother to her baby during pregnancy, at delivery and through breastfeeding.
- If a pregnant woman's HIV infection is found before she gives birth, she can be treated with drugs that fight the HIV virus during pregnancy and when she is in labor. The baby will receive the same drugs after birth. This medication can reduce the risk of passing the HIV virus to the baby.
- New Jersey law mandates that all pregnant women should be counseled about HIV infection and offered HIV testing as part of routine prenatal care. The pregnant woman should be tested for the HIV virus as soon as possible after entering prenatal care and during the third trimester of pregnancy.
- If a pregnant woman refuses testing during the third trimester of her pregnancy, her newborn baby will be tested for HIV infection within a few hours after birth.

What is the risk of an HIV infected pregnant woman passing HIV virus to her baby?

- If a woman does not get any treatment during her pregnancy or labor, 13 out of 50 babies will be infected.



- If a woman begins treatment during labor or her baby gets treatment soon after birth, or both, 5 out of 50 babies will be infected.



- If a woman gets treatment during her pregnancy and labor, and her baby gets treatment soon after birth, only 1 out of 50 babies will be infected.



What can you do to protect your baby?

- Know your HIV status. Get tested for HIV early in pregnancy and again in the third trimester.
- If a pregnant woman knows she has HIV, she can take drugs that fight the HIV infection throughout her pregnancy and labor to help prevent her baby from getting HIV.
- A woman with HIV may have a cesarean delivery (C Section) to help protect the baby from the disease. The doctor will talk to her about this option.
- It is important to know that HIV can pass through breast milk. A woman with HIV should not breastfeed.

How is the HIV test done?

- The HIV test is a blood test that can determine if you have been exposed to the HIV virus. The blood can often be drawn at the same time that other prenatal lab tests are being done. The results will usually take a few days to weeks.
- If there is no documented record of your HIV test result when you are admitted to Labor and Delivery, a special "rapid or expedited" test will be done. The "rapid or expedited" test is a blood test which can give us the results quickly.
- If a pregnant woman refuses to be tested in the third trimester, her baby will be tested for exposure to the HIV virus with a "rapid or expedited" blood test that will be drawn within a few hours after birth.

If you would like to learn more about HIV testing talk to your doctor or healthcare professional.

You can also contact the Center for Disease Control (CDC) at their website: <http://www.cdc.gov/hiv/topics/perinatal/>
By telephone 1-800-CDC-INFO (232-4636)



DESIGNATION OF NEWBORN PROVIDER

I _____, am choosing
Parent or Legal Guardian

Newborn Healthcare Provider's Name

Address

Telephone #

as my baby's pediatrician.

My pediatrician has privileges at this hospital and I understand that _____ or his/her designee will see my baby during this hospital admission.

My pediatrician does NOT have privileges at this hospital and:

I have elected _____ to see my baby during this hospital admission

I have not chosen a pediatrician for my baby and I understand that Pediatric Hospitalist Service will see my baby during this hospital admission. I also understand I will need to designate a pediatrician for my baby upon discharge.

The majority of the physicians at the hospital are not employees or agents of the hospital. They are members of the voluntary medical staff who are independent contractors and practitioners who have been granted the privilege of using the hospitals facilities for the care and treatment of their patients.

The hospital charges do not include the fees for the services provided by these independent physicians.

You will be responsible for the fees charged by these independent physicians, which will be billed separately and may not be covered by your insurance.

It is your responsibility to check to see if your plan covers the services of the provider. It is not the responsibility of the hospital to select the provider or cover their services.

Parent or
Legal Guardian Signature: _____ Date: _____ Time: _____

Name (Print): _____ Relationship to patient: _____

Witness Signature: _____ Date: _____ Time: _____

Name (Print): _____



ROUTINE NEWBORN CARE

I understand that during my newborn's stay in the hospital, a number of preventive, diagnostic and therapeutic procedures may be performed by the nurses and physicians caring for my newborn. The following procedures are routinely performed:

• **Eye Prophylaxis**

Description: Antibiotic ointment is instilled into the eyes of all newborns soon after birth. **Recommended for all newborns.**

Benefits: Prevention of serious eye infection that can cause blindness.

Risks: Mild irritation of the eyes.

• **Vitamin K Administration**

Description: An intramuscular injection of vitamin K is administered soon after birth. **Recommended for all newborns.**

Benefits: Prevention of bleeding and hemorrhage in the brain and internal organs that can lead to death or brain damage.

Risks: Soreness at the site of injection.

• **Hepatitis B Vaccine**

Description: An intramuscular injection of Hepatitis B vaccine is administered soon after birth to all newborns. **Recommended for all newborns.**

Benefits: Prevention of Hepatitis B infection of the infant.

Risks: Soreness at site of injection; low grade fever.

• **Critical Congenital Heart Defects Screening**

Description: Pulse Oximetry screening will be performed on all newborns to evaluate the oxygen level in the blood. A small probe is attached to the foot and to the wrist. **Mandatory for all newborns in the state of New Jersey.**

Benefits: Can identify babies with serious congenital heart disease.

Risks: None.

• **Transcutaneous Bilirubin**

Description: A non invasive technique to screen for bilirubin level in blood.

Benefits: Screens for hyperbilirubinemia, a common problem in newborns without a heel stick.

Risks: May not be as accurate as a serum blood draw.

• **Newborn Genetic and Biochemical Screening**

Description: A small blood sample is drawn by heelstick in order to detect the presence of a variety of congenital genetic and metabolic disorders. **Mandatory for all newborns in the state of New Jersey.**

Benefits: Detection of genetic and metabolic disorders so that they may be treated before causing injury or damage.

Risks: Bruising of the heel; rarely, infection resulting from the needle stick.

• **Hearing Screening**

Description: A clicking sound is presented to the baby through headphones. The response of the baby is detected by way of "echoes" which are generated by the ear itself (OAE) or a change in the electrical activity on the surface of the brain (ABR). **Mandatory for all newborns in the state of New Jersey.**

Benefits: Detection of hearing loss at a young age so that evaluation and treatment may be instituted promptly.

Risks: None.

• **Blood Tests**

Description: Blood tests may be performed to evaluate jaundice, blood sugar or blood count. The blood obtained by heelstick or venipuncture.

Benefits: Evaluation of various conditions so that the newborn may be treated quickly and appropriately.

Risks: Bruising of the heel; rarely, infection resulting from the needle stick.

NOT PART OF THE PERMANENT MEDICAL RECORD



PATIENT ID
HERE

DELIVERY ROOM PHOTOGRAPHER PERMIT

I, _____, hereby grant permission to the Significant Other or Photographer whose signature appears below to observe and photograph me and my baby during labor and delivery subject to any restrictions which may be imposed by the attending physicians, pediatricians, anesthesiologists and/or nurses. Additionally, if at any time the medical staff wish to discontinue audiovisual recordings, My Significant Other/Photographer and I will comply.

My Significant Other/Photographer and I agree to follow the hospital policy concerning Audiovisual Recording of the Mother and Baby. We will ask staff personnel for their consent prior to videotaping or photographing them.

We agree to comply with all rules and regulations of the hospital and the Obstetrical Department. We understand and agree that permission granted hereby can be revoked, modified or restricted as determined in the best interest of the patient, the baby, the Significant Other, the physicians or the staff.

We, on behalf of ourselves, our heirs, successors and assigns, agree to release and hold the hospital, its Directors, Officers, Agents and Employees, harmless from any and all claims, liabilities, demands, suits or causes of action which relate directly or indirectly to the audiovisual or photographic recording of me during labor and delivery including any loss or damages to property or personal injury or death that may occur as a direct or indirect result of the audiovisual or photographic recording. Such release and hold harmless shall also apply to the attending physician, his/her assistants, and any and all other healthcare personnel attending me.

The Significant Other/Photographer agrees to adhere to any restrictions made by the patient regarding the use of the photographs or disclosure of the identity of the patient. We agree that no reference will be made to Atlantic Health System, its employees or the physicians without the specific written consent of the hospital in the event of the photographs obtained pursuant to this authorization are published or displayed.

We have read the forgoing and agree to be bound by its terms.

Patient: _____ Date: _____ Time: _____

Name (Print): _____

Significant Other/Photographer: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____

Name (Print): _____



DT1200

State of New Jersey Department of Health

NOTICE OF AVAILABILITY OF SUPPLEMENTAL NEWBORN SCREENING

New Jersey law mandates that every baby born in New Jersey be screened for 54 disorders that can cause serious health problems. These disorders may not be apparent at birth, but if left undetected and not treated early in life, can lead to problems that include mental retardation, disability, or even death.

The New Jersey Department of Health Newborn Screening Program performs screening tests for these 54 disorders on all newborns within 48 hours after birth. The State laboratory uses an advanced technology, called tandem mass spectrometry (MS/MS), to test for these disorders. This technology may detect the presence of additional disorders for which screening is not mandated. If the State laboratory detects the presence of any disorder, the State will notify your health care provider.

New Jersey law requires health care providers to provide this pamphlet to expectant parents and guardians to advise you of the following. Supplemental newborn screening is available for other disorders in addition to the 54 disorders for which State law mandates screening. The State does not perform supplemental newborn screening. Private laboratories provide supplemental newborn screening. Supplemental newborn screening is optional. Your health care provider may recommend that supplemental newborn screening be performed. The cost for supplemental newborn screening is an out-of-pocket expense. The screening tests that private laboratories perform may repeat the tests for some or all of the 54 disorders for which the State already conducts screening.

If you decide to have supplemental newborn screening performed:

- Preferably several months in advance of your delivery date, you will need to purchase a supplemental screening test kit from a laboratory authorized by the Centers for Medicare and Medicaid Services (CMS).
- You will have to read and follow the instructions provided with the test kit, and tell your health care provider that you want supplemental screening.
- Typically, your health care provider will have to sign an order for the test, and the private laboratory will send the results to your health care provider.
- The State Newborn Screening Program will not receive the supplemental screening test results.

Reference in this notice to any specific commercial service, company, or organization does not constitute an endorsement or recommendation by the New Jersey Department of Health. The Department is not responsible for the content of any web page for which a link is provided below. If you have any questions, please contact your health care provider. Staff of the Department's Newborn Screening Follow-up Program and the Newborn Screening Laboratory, for whom contact information is given below, can provide you with information but cannot give medical advice and cannot advise as to whether to have supplemental newborn screening performed. This information is subject to change.

Informational Websites

Save Babies: www.savebabies.org
March of Dimes: www.marchofdimes.com
GeNeS-R-US: www.genes-r-us.uthscsa.edu
Gene Clinics: www.geneclinics.org

CMS Laboratory Information

www.cms.hhs.gov/clia
Phone: (877) 267-2323

Newborn Screening Follow-up Program

Lorraine Freed Garg, M.D., M.P.H.
E-mail: Lori.Garg@doh.state.nj.us
(609) 984-0755

Newborn Screening Laboratory

Scott M. Shone, Ph.D.
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Atlantic
Health System



DT1200

**ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF AVAILABILITY OF
SUPPLEMENTAL NEWBORN
SCREENING**

PATIENT ID
HERE

By signing this form, I confirm that:

- My health care provider gave me the pamphlet titled “New Jersey Department of Health Notice of Availability of Supplemental Newborn Screening” and I kept a hard copy of the pamphlet;
- My health care provider gave me a reasonable opportunity to read the pamphlet;
- I understand that mandatory newborn screening that the State will perform will not detect all possible disorders in infants for which tests are available;
- I understand that I am personally responsible for the cost of supplemental newborn screening; and
- I understand that if I choose to have supplemental newborn screening performed, then, several months in advance of the expected delivery date, I need to order the necessary kit from a laboratory of my choice and inform my health care provider that I want supplemental newborn screening performed.

Signature: _____

Print name: _____

Date: _____

Relationship to newborn (*circle one*) Parent Guardian

Witness to signature: _____

Print name of witness: _____

The health care provider shall maintain the signed original of this acknowledgement. The health care provider shall give the signer the pamphlet titled “New Jersey Department of Health Notice of Availability of Supplemental Newborn Screening.”

SCH-7
JUL 12

For updates of this pamphlet, go to www.nj.gov/health/fhs/schome.htm

Last updated JULY 2012

Notice of Privacy Practices

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.***

I. Who We Are:

We are Atlantic Health System, Inc. This Notice describes the privacy practices of Atlantic Health System (its hospitals, other medical facilities and companies) and the physicians, nurses, technicians and other individuals who work at or in conjunction with Atlantic Health System (“Atlantic,” “we” or “us”). Atlantic participates in an Organized Health Care Arrangement (“OHCA”). An OHCA is an arrangement or relationship that allows two or more covered entities to use and disclose “Protected Health Information” or “PHI” (as defined in Section II below). A “covered entity” is any organization that directly handles PHI. The separate covered entities and service delivery sites which comprise Atlantic’s OHCA are its hospitals, clinics, physician practices, affiliated physician practices, members of Atlantic’s clinically integrated network, participants in Atlantic’s and its affiliates’ accountable care organizations, outpatient centers, urgent care centers, walk-in clinics, imaging centers, ambulatory surgery centers, integrative medicine facilities, skilled nursing facilities, rehabilitation facilities, visiting nurses and home health associations, mobile health company, members of employers health plan consortium, and insurance companies that have chosen to participate in the OHCA. These entities may share PHI among themselves as necessary to carry out treatment, payment and health care operations relating to the OHCA and for other purposes as permitted or required by law. The entities participating in the OHCA agree to abide by the terms of this Notice with respect to PHI created or received by the entity as part of its participation in the OHCA.

II. Our Commitment to Your Privacy:

We are dedicated to maintaining the privacy of your medical information. In conducting our services, we will create records regarding you and the treatment and services we provide to you (including records relating to psychiatric treatment, drug and alcohol treatment or abuse or HIV status, if any). These records are our property; however, we are required by law to maintain the privacy of medical and health information about you (“Protected Health Information” or “PHI”) and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. When we use or disclose PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure). determine paternity, newborn screening, identifying your body or as otherwise authorized by a court order).

III. Uses and Disclosures With Your Authorization:

A. Use or Disclosure with Your Authorization. We may use or disclose PHI only when (1) you give us your written authorization on a form (“Your Authorization”) that complies with the Health Insurance Portability and Accountability Act (“HIPAA”), including for certain marketing activities, sale of health information, and (with some exceptions) the disclosure of psychotherapy notes about you, or (2) there is an exception to the authorization requirement as described in Section IV. Further, except to the extent that we have taken action in reliance upon it, you may revoke Your Authorization by delivering a written revocation statement to the Privacy Officer identified in Section VII.

B. Genetic Information. Except in certain cases (such as a paternity test for a court proceeding, anonymous research, newborn screening requirements or pursuant to a court order), we will obtain Your Authorization prior to obtaining or retaining your genetic information (for example, your DNA sample). We may use or disclose your genetic information for any reason only when Your Authorization expressly refers to your genetic information or when disclosure is permitted under New Jersey State law (including, for example, when disclosure is necessary for the purposes of a criminal investigation, to determine paternity, newborn screening, identifying your body or as otherwise authorized by a court order).

C. Information about AIDS or HIV and Certain Venereal Diseases. If PHI contains AIDS or HIV related information or information concerning certain venereal diseases, that information is confidential and generally will not be disclosed without Your Authorization expressly releasing such information. However, such information may be released without Your Authorization to medical personnel directly involved in your medical treatment or as required by law to relevant oversight agencies such as the New Jersey Department of Health. If you are deemed to lack decision-making capacity, we may release such information (only if necessary and unless you request otherwise) to the person responsible for making health care decisions on your behalf (spouse, primary caretaking partner, an appropriate family member, etc.). Under certain circumstances, such information may also be released without Your Authorization for scientific research, certain audit and management functions, and as may otherwise be allowed or required by law or court order.

D. Alcohol or Drug Abuse Programs. If PHI contains information related to diagnosis or treatment provided in an alcohol or drug abuse program, that information is confidential and will not be disclosed without Your Authorization expressly releasing alcohol or drug abuse diagnosis or treatment related information except in accordance with applicable law, including federal regulations regarding the confidentiality of alcohol and drug patient records.

IV. Uses and Disclosures Without Your Authorization:

A. Use and/or Disclosure for Treatment, Payment and Health Care Operations. Except as noted in Sections III B, C, and D, we may use and/or disclose PHI without Your Authorization for treatment provided to you, obtaining payment for services provided to you and for health care operations (e.g., internal administration, quality improvement, customer service, etc.) as detailed below:

- **Treatment.** We use and disclose your PHI to provide treatment and other services to you - for example, a doctor treating your injury or illness may allow another doctor to review your PHI for assessment of your overall health condition. We may also disclose your PHI to a health care provider outside of Atlantic or receive your PHI from a health care provider outside of Atlantic for that health care provider's and/or our treatment activities.

In addition, unless you opt out (e.g., disagree or object) as described in Section V, any authorized health care provider who agrees to participate in a Health Information Exchange ("HIE"), can also electronically access and use your PHI to provide treatment to you. If you opt out of each HIE as described in Section V, your PHI will not be shared electronically through the HIE network; however, it will not impact how your information is otherwise typically accessed, used and released in accordance with this Notice and the law.

- **Payment.** We may use and disclose your PHI to obtain payment for services that we provide to you - for example, we may disclose your PHI to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payor") and to verify that Your Payor will pay for your health care. We may also disclose your PHI to another health care provider or covered entity for the payment activities of that health care provider or covered entity.
- **Health Care Operations.** We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you (including operating and troubleshooting our health information technology). For example, we may use your PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. In addition, we may disclose your PHI

to external licensing or accrediting bodies for purposes of hospital licensure and review. We may disclose your PHI to our patient representatives in order to resolve any complaints you may have and ensure that you have a comfortable visit with us. In some cases, we may use or disclose your PHI to arrange for or conduct legal services that relate to our health care provider functions. Under certain circumstances, we may disclose your PHI to another health care provider for the health care operations of that health care provider if they either have treated or examined you and your PHI pertains to that treatment or examination.

B. Use or Disclosure for Directory of Individuals in Atlantic's Facilities. Unless you opt out (e.g., disagree or object), we may include your name, location in Atlantic's facility, general health condition and religious affiliation in a patient directory. Information in the directory may be disclosed to anyone who asks for you by name or members of the clergy (provided, however, that religious affiliation will only be disclosed to members of the clergy). You may opt out of the directory by notifying our Privacy Officer. If you opt out, we cannot tell members of the public or your family and friends that you are admitted to the hospital. Please think carefully about the consequences of the decision to opt out.

C. Disclosure to Relatives and Close Friends. We may disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we: (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interest. If we disclose information to a family member, other relative, a close personal friend or other person identified by you, we would disclose only information that is directly relevant to the person's involvement with your health care, payment related to your health care or needed for notification purposes.

D. Fundraising Communications. We may contact you to request a tax-deductible contribution to support fundraising activities of Atlantic. In connection with any fundraising without Your Authorization, we may disclose to our related foundation/fundraising staff the following information about you: demographics (e.g., your name, address, other contact information, age, gender and date of birth), dates on which we provided health care to you, department of service information, treating physician, outcome information and health insurance status. In each fundraising communication you receive from us, you will be provided with information on how to opt out of receiving further fundraising communications from us if you so choose.

E. Public Health Activities. We may disclose PHI for public health activities and purposes, including, without limitation: (1) to report health information, including but not limited to information concerning disease, injury and vital

events such as birth or death, to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and (6) to report your immunization status to your school if your school is required to have proof of your immunization and you or your parent or guardian agrees to the disclosure.

F. Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the health care system and ensures compliance with the rules of government health programs such as Medicare or Medicaid.

G. Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

H. Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials, including as required by law; in compliance with a court order; in response to a request for information about a victim of a crime, suspect, fugitive, witness, or missing person; to report evidence of criminal conduct on Atlantic's premises; to report a death that Atlantic suspects may have resulted from criminal conduct; or to report a crime in an emergency situation.

I. Decedents. We may disclose your PHI to a coroner or medical examiner as authorized by law. We may also release medical information about patients at Atlantic to a funeral director as necessary to carry out his or her duties.

J. Organ and Tissue Procurement. We may disclose your PHI to organizations engaged in organ, eye or tissue procurement, banking or transplantation for the purpose of facilitating organ, eye or tissue donation and transplantation.

K. Research. We may use or disclose your PHI without your consent or authorization for research where permitted by law.

L. Health or Safety. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

M. Specialized Government Functions. We may use or disclose your PHI for certain government functions as permitted by law, including as required by military command authorities if you are a member of the armed forces, and to authorized federal officials for certain national security and intelligence activities and for presidential protection.

N. Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

O. Victims of Abuse, Neglect or Domestic Violence.

If we reasonably believe that you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to a government authority, including social service or protective services agencies, authorized by law to receive reports of such abuse, neglect or domestic violence. We will inform you if any such disclosure has been made except in cases where, in the exercise of our professional judgment, informing you would place you at risk of serious harm or would not be in your best interests.

P. Inmates. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your PHI to the correctional institution or law enforcement official, provided that such disclosure is necessary:

- for the provision of health care to you,
- to protect your health and safety or the health and safety of other inmates, or
- for the safety and security of the correctional institution

Q. Health Information Exchange ("HIE"). Atlantic and other health care providers participate in certain HIEs as Atlantic and such other health care providers may determine from time to time. These HIEs allow patient information to be shared electronically through a secured connected network. HIEs give your health care providers who participate in the HIE networks immediate electronic access to your pertinent medical information for treatment, payment and certain health care operations. If you do not opt out of a HIE, your information will be available through such HIE network to your authorized participating providers in accordance with this Notice and the law. If you opt out of a HIE (as described in Section V), this will prevent your information from being shared electronically through the HIE network; however, it will not impact how your information is otherwise typically accessed, used and released in accordance with this Notice and the law.

Any exception that denies an individual from opting out of having their information transmitted through the HIE shall be in accordance with applicable federal and state law.

R. As Required by Law. We may use and disclose your PHI when required to do so by any other law or regulation not already referenced above.

S. Incidental Disclosures. We may disclose your PHI incident to a use or disclosure that is otherwise permitted as described in this Notice. For example, if one of our physicians discloses your PHI in confidential conversation with you for treatment purposes, another provider or a patient may overhear the conversation. Atlantic has implemented reasonable safeguards as well as policies and procedures regarding minimum necessary use and disclosure of PHI in an effort to minimize such incidental disclosures and protect your privacy.

V. Your Individual Rights:

A. For Further Information, Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to grant your request, and we may deny your request if it would affect your care. However, if you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer and in those circumstances we will not share your information per your request unless a law requires us to share that information. If you wish to request additional restrictions, please obtain a request form from, and submit the completed form to, our Privacy Officer. We will send you a written response.

C. Right to Receive Confidential Communications. You may request that we communicate with you about your PHI by alternative means or at alternative locations. To make such a request, you must submit your request in writing to our Privacy Officer.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records and in such case, we will inform you of the specific basis for the denial and will explain your rights. If you desire access to your records, please obtain a record request form from, and submit the completed form to, our Privacy Officer.

You should take note that, if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you in accordance with applicable law (for example, records relating to pregnancy, abortion, sexually transmitted disease, substance use and abuse, contraception and/or family planning services).

E. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from, and submit the completed form to, our Privacy Officer. In some cases, we have the right to deny your request for amendment. If we deny your request for an amendment, we will provide you with a written explanation of why we denied the request and will explain your rights.

F. Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures

of PHI made by us during any period of time prior to the date of your request, in accordance with applicable laws and regulations, provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we may charge you the cost of providing the accounting statement. To request an accounting of disclosures, please obtain a form from, and submit the completed form to, our Privacy Officer.

G. Right to Receive Notice of a Breach. You have a right to be notified by us if you have been affected by a breach of unsecured PHI and we are required by law to provide you with such notice.

H. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you agreed to receive such Notice electronically. You can also access this Notice on our website at: www.atlantichealth.org.

I. Right to Opt Out of HIEs. We may participate in certain HIEs, whereby we may disclose your health information, as permitted by law, to other health care providers or entities that participate in the HIE for treatment, payment, or health care operations. Other participating health care providers, such as physicians, hospitals and other health care facilities, may also have access to your information in the HIE for similar purposes to the extent permitted by law. If you do not wish to allow otherwise authorized physicians, nurses, clinicians and other healthcare providers involved in your care to electronically share your PHI with each other through an HIE, you have the right to opt out of the HIE. To exercise this opt out right, please contact our Privacy Officer.

VI. Effective Date and Duration of This Notice:

A. Effective Date: This Notice is effective as of April 13, 2003.
Revision Dates: October 1, 2011, June 1, 2012, June 7, 2013, July 15, 2014, April 1, 2017, December 1, 2019.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new Notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new Notice. If we change this Notice, we will post the new Notice in waiting areas around Atlantic and on our Internet site at www.atlantichealth.org. You also may obtain any new Notice by contacting our Privacy Officer.

VII. Privacy Officer:

You may contact the Privacy Officer at:

Eva J. Goldenberg, Esq.
Vice President, Corporate Compliance & Internal Audit
Chief Compliance Officer
Privacy Officer
Atlantic Health System, Inc.
475 South Street, P.O. Box 1905
Morristown, New Jersey 07962
Telephone Number: (973) 660-3143
E-mail: eva.goldenberg@atlantichealth.org



ADVANCE DIRECTIVE FOR HEALTH CARE

INSTRUCTION DIRECTIVE

An **Instruction Directive for Health Care**, sometimes called a **Living Will**, is a written document, signed by you, in which you decide the kind of care you would want, if for any reason you are unable to make health care decisions for yourself.

You do not need to have a Living Will, but having one will avoid many problems. It will let your physician, family, and friends know ahead of time what kind of decisions should be made for you if you become disabled, physically or mentally, and are unable to decide for yourself. You will receive appropriate medical care whether or not you have an Advance Directive.

PROXY DIRECTIVE- DURABLE POWER OF ATTORNEY FOR HEALTH CARE

In addition to your Instruction Directive, we encourage you to fill out a **Proxy Directive** in which you designate a health care representative, for example, a family member, friend, or other person who understands your feelings and is willing to make decisions for you about accepting, refusing, or withdrawing treatment if you become unable to do so for yourself.

This four-page document includes a list of definitions and the above two types of Advance Directives (together called a **Combined Directive**). Some people choose to fill out only one of these forms. We recommend that you fill out both.

Before filling out these forms, you are encouraged to speak with your doctor, family, health care representative, or others who may become responsible for following your wishes. Once you sign and date these forms and have them witnessed by two individuals, your requests must be followed by anyone involved in your care, but only at a time when you are not capable of making decisions for yourself.

After you fill out your Advance Directive, we recommend that you keep the original and give copies to your appointment health care representative, your physician, and any other family member, close friend, or advisor who is interested in your health and well-being.

Written and approved by the Medical Society of New Jersey 7/95.

TERMS YOU SHOULD UNDERSTAND

A. Life-Sustaining Treatment

1. *Cardiopulmonary Resuscitation (CPR)*. CPR describes procedures that are done to restart the heart when it stops beating (“cardiac arrest”), and/or to provide artificial respiration when breathing stops (“respiratory arrest”). CPR can involve manual pressure to the chest and mouth-to-mouth breathing or pumping of air into the lungs using a rubber bag. In some instances, a tube may be inserted into the windpipe (“intubation”) for mechanical ventilation.
2. *Mechanical Ventilation or Respiration*. A machine called a respirator or ventilator can take over breathing if the lungs cannot adequately breathe. It provides oxygen through a tube inserted into the windpipe.
3. *Surgery*. A surgical procedure involves cutting into the body to treat a problem.
4. *Chemotherapy*. Chemotherapy is drug treatment for cancer. It is used to cure cancer or reduce the discomfort of cancer even if it does not cure it.
5. *Radiation Therapy (RT)*. RT involves the use of high levels of radiation to shrink or destroy a tumor.
6. *Dialysis*. Dialysis requires the use of a machine that cleanses the blood when the kidneys cannot function adequately. This can be done through tubes placed into blood vessels (hemodialysis) or through tubes into the abdomen (peritoneal dialysis).
7. *Transfusion*. The transfusion refers to the giving of any type of blood product into a vein intravenously.
8. *Artificially Provided Nutrition and Fluids*. This group of terms refers to feeding patients who are unable to swallow food and fluid. This can be done through a tube into a vein or into the stomach. The feeding tube to the stomach can be placed through the nose (nasogastric tube) or through the abdomen (gastrostomy tube.)
9. *Antibiotics*. Antibiotics are medications used to fight infections. They can be administered by mouth, by vein, by injection into a muscle, or through a feeding tube.

B. Comfort and Supportive Care (Palliative Care)

Comfort care is any kind of treatment that increases a person’s physical or emotional comfort. Comfort care includes adequate pain control. It may also include oxygen, food and fluids by mouth, moistening of the lips, cleaning, turning, touching a person, or simply sitting with someone who is bedridden.

C. Medical Conditions

1. *Terminal Condition*. The end stage of an irreversibly fatal illness, disease, or condition.
2. *Permanent Unconsciousness*. A medical condition that is total and irreversible in which a person cannot interact with his/her surroundings or with others in any way and in which a person does not experience pleasure or pain

**INSTRUCTION DIRECTIVE
(Living Will)**

To My Family, Doctors, and All Those Concerned with My Care:

I, _____, being of sound mind, make this statement as a directive to be followed if for any reason I become unable to participate in decisions regarding my medical care (Initial any that apply.)

A. _____ 1. I direct that life-sustaining procedures be withheld or withdrawn a) if I become permanently unconscious, b) if I have a terminal illness, c) if I experience extreme mental deterioration, or d) if I have another type of irreversible illness. The above conditions shall have no reasonable expectation of recovery or chance of regaining a meaningful quality of life. These medical conditions shall be determined by my attending physician and at least one additional physician. I understand that I will be kept comfortable.

OR

_____ 2. I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

B. This section asks you to think about the values that are important to you regarding treatment in case of severe mental or physical illness.

_____ 1. I do not wish my life to be prolonged by medical treatment(s) if my quality of life is unacceptable to me. The following are conditions that are unacceptable to me. (Initial only those that describe a way of living that you could not tolerate):

_____ a) Permanently unconscious with a ventilator breathing for me.

_____ b) Permanently unconscious with a feeding tube and/or intravenous (IV) hydration.

_____ c) On a ventilator when there is little or no chance of recovery.

_____ d) Being conscious (awake), but unable to communicate (for example, with a stroke), and being fed with a feeding tube and/or hydrated with IVs to keep me alive.

_____ e) Living with a dementia like Alzheimer's disease so severe that I am unable to recognize those who love me.

OR

_____ 2. I want to live as long as possible, regardless of the quality of life that I experience.

C. If you choose A. 1., above, the life-sustaining procedures that would be withheld or withdrawn include but are not limited to: CPR, mechanical ventilation, surgery, chemotherapy, radiation, dialysis, transfusion, and antibiotics. Initial the following if it applies to you (see "Terms You Should Understand")

_____ In the circumstances described in A.1., above, I also direct that artificially provided nutrition and fluids be withheld and withdrawn and that I be allowed to die.

D. _____ Upon my death, I am willing to donate any parts of my body that may be beneficial to others.

Additional Comments or Exceptions: _____

These directions express my legal right to request or refuse treatment. Therefore, I expect my family, doctor, and all those concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes.

Signed _____ **Date** _____

Witnesses (cannot be health care representative or alternative representative if any are named on the other side of this page). I declare that the person who signed this document, or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness _____ **Date** _____

Witness _____ **Date** _____

Reminder: Give a copy of this document to your doctor, health care representative, and other concerned individuals.

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(Proxy Directive)**

If you wish, you may use this section to designate someone to make treatment decisions if you are unable to do so. Your Living Will declaration will be in effect even if you have not designated a proxy.

I, _____, designate the following person as my health care representative to make any and all health care decisions for me acting in my best interest, in the event that i become incapable of making decisions for myself.

Name _____ Relationship _____

Street _____

City _____ State _____ Telephone _____

If the person I have named above is unable to act as my health care representative, I hereby designate the following person(s) to do so:

1. Name _____ Relationship _____

Street _____

City _____ State _____ Zip _____ Telephone _____

2. Name _____ Relationship _____

Street _____

City _____ State _____ Zip _____ Telephone _____

SPECIFIC DIRECTIONS: Please initial the statement below that best expresses your wishes.

_____ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or IV infusion, be withheld or withdrawn.

_____ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

Signed _____ Date _____

Witnesses (cannot be health care representative or alternative representative listed above.)

I declare that the person who signed this document, or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness _____ Date _____

Witness _____ Date _____

***Reminder: Give a copy of this document to your doctor, health care representative, and other concerned individuals.**



DT321

PATIENT ID
HERE

BIRTH CERTIFICATE WORKSHEET

Please print clearly and answer ALL items on this form in blue or black ink.

After completing, please return promptly for review.

OFFICE ONLY:

Medical Record: _____
 Child Date-Time of Birth _____
 If Plural _____ of _____
 Sex: _____

CHILD'S INFORMATION

Child Name (Legal Name to Appear on Birth Certificate)

First: _____ Middle: _____ Last: _____ Suffix: _____

Request Social Security Number for child? Yes No

MOTHER/PARENT A'S INFORMATION

Current Legal Name

First: _____ Middle: _____ Last: _____ Suffix: _____

Maiden Name (Full Name Given at Birth or on Birth Certificate):

First: _____ Middle: _____ Last: _____ Suffix: _____

SSN#: _____ - _____ - _____ Date of Birth: ____/____/____ (MM/DD/YYYY) Birth Place (State/Country): _____

Mother/Parent A's Residence Address Information

Street Address: _____ Apt: _____ City/Town: _____ Zip: _____

State/Country: _____ Municipality: _____ County: _____

Does Mother/Parent A Reside within City Limits? Yes No Residing at current residence for: Years _____ Months _____

Phone #: _____ **Mailing Address** - Same as Residence? Yes No, Specify: _____

Street Address: _____ Apt: _____ City/Town: _____ Zip: _____

State/Country: _____ Municipality: _____ County: _____

Mother/Parent A's Marital Status

- Never Married Married Married, Husband Info Refused Widowed, 300 Days or More Divorced, 300 days or More
 COP requested

Mother/Parent A's Education and Employment (Describe the highest degree or level of school completed)

- 8th grade or less Associate degree (e.g., AA, AS)
 Some college credit but no degree Bachelor's degree (e.g., BA, AB, BS)
 9th-12th grade, no diploma Master's degree (e.g., MA, MS, MEng, MSW, MBA)
 High school graduated GED completed Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

Mother/Parent A's Business/Industry: _____ Mother/Parent A's Occupation: _____

Was Mother/Partner A Employed during the past year? Yes No

Employer Name: _____

Employer Street Address: _____ Employer City: _____

Employer Zip: _____ Employer State/Country: _____ Employer County: _____

Hispanic Origin

- No, not Spanish/Hispanic/Latino Yes, Puerto Rican Yes, other Spanish/Hispanic/Specify: _____
 Yes, Mexican, Mexican American, Chicano Yes, Cuban Refused

Mother/Parent A's Race

- White Chinese Vietnamese Samoan
 Black or African American Filipino Other Asian (Specify): _____ Other Pacific Islander (Specify): _____
 American Indian or Alaska Native (Tribe): _____ Japanese Native Hawaiian Other (Specify): _____
 Asian Indian Korean Guamanian or Chamorro Refused

What language would be best to use when giving you information about your baby's health care?

English Spanish Hindi Mandarin Chinese Hatian Creole Portuguese Other (Specify): _____

Source of future care: _____

Do you have any children diagnosed with an Autism Spectrum Disorder? Yes No N/A



DT321

PATIENT ID
HERE

BIRTH CERTIFICATE WORKSHEET

FATHER/PARENT B'S INFORMATION

Father/Parent B's Information not provided

Father/Parent B's Name:

First: _____ Middle: _____ Last: _____ Suffix: _____

Birth Place (State/Country): _____ Date of Birth: ____/____/____ (MM/DD/YYYY)

SSN#: _____ - _____ - _____

Father/Parent B's Residence Address Information

Is Father/Parent B's Residence same as Mother/Parent A's Residence? Yes No, Specify: _____

Street Address: _____ Apt: _____ City/Town: _____ Zip: _____

State/Country: _____ Municipality: _____ County: _____

Residence Phone Number: _____

Mailing Address - Same as Residence? Yes No, Specify: _____

Street Address: _____ Apt: _____ City/Town: _____ Zip: _____

Street Address: _____ Apt: _____ City/Town: _____ Zip: _____

Father/Parent B's Education and Employment (Describe the highest degree or level of school completed)

- | | |
|--|--|
| <input type="checkbox"/> 8th grade or less | <input type="checkbox"/> Associate degree (e.g., AA, AS) |
| <input type="checkbox"/> Some college credit but no degree | <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) |
| <input type="checkbox"/> 9th-12th grade, no diploma | <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MSW, MBA) |
| <input type="checkbox"/> High school graduated GED completed | <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD) |

Father/Parent B's Business/Industry: _____ Father/Parent B's Occupation: _____

Was Father/Partner B Employed during the past year? Yes No

Employer Name: _____

Employer Street Address: _____ Employer City: _____

Employer Zip: _____ Employer State/Country: _____ Employer County: _____

Hispanic Origin

- | | | |
|--|--|---|
| <input type="checkbox"/> No, not Spanish/Hispanic/Latino | <input type="checkbox"/> Yes, Puerto Rican | <input type="checkbox"/> Yes, other Spanish/Hispanic/Specify: _____ |
| <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano | <input type="checkbox"/> Yes, Cuban | <input type="checkbox"/> Refused |

Father/Parent B's Race

- | | | | |
|--|-----------------------------------|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Chinese | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Filipino | <input type="checkbox"/> Other Asian (Specify): _____ | <input type="checkbox"/> Other Pacific Islander (Specify): _____ |
| <input type="checkbox"/> American Indian or Alaska Native (Tribe): _____ | <input type="checkbox"/> Japanese | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Other (Specify): _____ |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Korean | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Refused |

INSURANCE INFORMATION

Is Mother/Parent A insured? Yes No

Is Father/Parent B insured? Yes No

If Yes, Mother/Parent A's Insurance Provider: _____

If Yes, Father/Parent B's Insurance Provider: _____

Mother/Parent A Insurance Policy number _____

Father/Parent B Insurance Policy number _____

PRINCIPAL SOURCE OF PAYMENT

- | | | | |
|--|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Medicaid/NJ Family Care | <input type="checkbox"/> Self-Pay/Charity Care | <input type="checkbox"/> Other _____ | Insurance Policy Holder _____ |
| <input type="checkbox"/> Private Insurance | <input type="checkbox"/> Unknown | | |

Did you participate in WIC during pregnancy? Yes No **If yes, what was your WIC Number?** _____

INFORMANT'S INFORMATION

First _____ Middle _____ Last _____

Relationship to Child _____ Signature _____ Date signed ____/____/____ (MM/DD/YYYY)

Tdap Vaccine

A SPECIAL OPPORTUNITY FOR MOM AND HER PARTNER

At Atlantic Health System we understand it is important for all adults who care for babies under one year old to receive the Tetanus, Diphtheria, Pertussis (Tdap) vaccine. Mom should get this vaccine during pregnancy. If she did not receive it during her pregnancy, she and her partner may get the vaccine while at the hospital or at a local pharmacy.

What is Pertussis (Whooping Cough)?

Pertussis is caused by bacteria. It spreads from person to person. Pertussis causes severe coughing spells, vomiting and loss of sleep. The violent coughing can lead to loss of weight, incontinence, fractures of the ribs and passing out. Sometimes people with pertussis need to be hospitalized or have complications like pneumonia.

Why are Babies at Risk?

Babies cannot get their vaccine for pertussis until they are two months old. They need to get three doses of the vaccine (two, four and six months) to be fully protected from the disease. Until they get the vaccine, the only way to protect them is to make sure that the adults who spend time with them do not give pertussis to them. Adults who had the pertussis vaccine when they were children may still get pertussis because their immunity may be low. The only way they can protect their babies is to get a Tdap vaccine.

Who should NOT take the vaccine?

People who have had a severe allergic reaction to the Tdap vaccine or its parts.

Three Easy Steps for Partners to Get the Tdap Vaccine:

› **Get a prescription from your doctor**

If you want to get the vaccine, but do not have a regular medical doctor, tell mom's Maternity Center nurse. The nurse will also review and have you sign the vaccine acceptance form.

› **Register with Central Access/Admitting just off the main hospital lobby**

Be sure to bring the prescription, your insurance card, vaccine acceptance form and a photo identification card.

› **Bring your paperwork to the Maternity Center and give to mom's nurse**

For more information about pertussis and the Tdap vaccine, please speak with your health care provider, your baby's health care provider or visit the Centers for Disease Control website at www.cdc.gov/vaccines.

We hope this information was helpful.

If you find you have other questions please feel free to reach out to us.

<i>Nurse Manager</i>	<i>908-522-4838</i>
<i>Pre-Registration Office</i>	<i>908-522-2304</i>
<i>Parent Education Office</i>	<i>908-522-2946</i>
<i>To schedule a tour</i>	<i>1-800-247-9580</i>
<i>Patient Billing Office</i>	<i>1-800-619-4024</i>
<i>Birth Certificate</i>	<i>908-522-3529</i>

Notes:

Notes:

Notes:

Overlook Medical Center

99 Beauvoir Avenue
Summit, NJ 07901

For a referral to an Atlantic Health System physician,
call 1-800-247-9580 or visit atlantichealth.org

OMC-41976-20
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Atlantic
Health System

Overlook Medical Center