MATERNAL AND NEWBORN INFORMED-CONSENT LIMITATIONS AND REFUSALS
Name: _____ DOB: _____
Expected Due Date: _____ Provider: _____
Intended Facility (if emergency transfer): _____

Purpose
This statement asserts my rights under Florida Statute §381.026 – The Florida Patient's Bill of Rights and Responsibilities. I, the undersigned, am of sound mind and fully capable of informed decision-making. I retain complete authority over medical decisions for myself and my newborn child. I do **not consent** to any testing, medication, injection, or procedure unless I have been fully informed of its purpose, risks, benefits, and alternatives, and have given explicit verbal or written consent at that time. I understand and accept full responsibility for my decisions. I grant permission only for interventions necessary to prevent **immediate, life-threatening harm** when there is no opportunity for informed discussion.

Specific Limitations and Refusals
I hereby decline, refuse, or restrict the following unless medically required for emergency stabilization:

1. **IV Lines & Medications** – Decline routine IV placement, fluids, or administration of Pitocin or other uterotonics except for urgent medical need. **Cytotec (misoprostol)** is **strictly declined** unless used postpartum for emergent hemorrhage control, and only with explicit consent in the moment.

2. **Vaginal or Cervical Examinations** – Only upon my explicit verbal consent at each instance.

3. **Electronic Fetal Monitoring** – Intermittent auscultation preferred; continuous monitoring only if clinically indicated for emergency purposes.

4. **Cord Management** – Request physiological (delayed) cord clamping and intact cord until pulsation ceases, unless immediate neonatal resuscitation requires earlier clamping.

5. **Newborn Prophylaxis** – Decline Vitamin K injection except in the event of a verified, current active bleed where immediate intervention is warranted; proof of bleed and my consent must be documented. Decline Hepatitis B vaccination and erythromycin eye ointment.

6. **Blood Sampling & Metabolic Screening** – Permit newborn metabolic screen (heel prick) for knowledge use only; samples may not be stored, shared, or used for research beyond that purpose.

7. **Newborn Separation** – Require immediate and continuous skin-to-skin contact and uninterrupted bonding. No removal of baby for routine procedures or observation without my consent.

8. **Cesarean or Operative Birth** – Consent only after full discussion and explicit agreement, unless delay would pose immediate life-threatening danger.

9. **Fundal Massage** – No fundal massage unless active postpartum hemorrhage or uterine atony is clearly observed and explained.

10. **Drug or Toxicology Testing** – No urine, blood, cord, or meconium drug screens for myself or my baby without explicit consent and discussion of medical necessity.

11. **Other Interventions** – Decline artificial rupture of membranes, induction or augmentation drugs, routine episiotomy, or fundal pressure unless emergently indicated.

Representation and Advocacy
My husband, _____, and my midwife, _____, are designated as my advocates and representatives to communicate and uphold my birth plan and consent limitations on my behalf if I am unable to do so.

Emergency-Care Clause
If a genuine, time-sensitive emergency arises that threatens life or irreversible harm, I authorize the attending clinician to perform the **minimum necessary interventions** for stabilization while honoring my preferences whenever possible. I request that all actions be explained to me or my designated advocate as soon as practical.

Documentation of Refusal
If any healthcare provider disagrees with or overrides these decisions, I request that: My refusal be recorded in my medical chart, The provider's full name, credentials, and reason for disagreement be documented, and I receive a copy of the documentation for my records.
Provider Acknowledgment (Optional)
I have reviewed this statement with the patient.
Provider Name & Title: _____ Date: _____
Signature: _____

Patient Declaration
I have read and understand this statement and sign it voluntarily.
Patient Signature: _____ Date: _____
Witness or Notary (if applicable): _____ Date: _____