Consents for Treatment

NAME CLIENT NUMBER

ULTRASOUND:

YES / REFUSED **DATE** ______________

GBS

YES / REFUSED **DATE** ______________

RESULTS: **NEGATIVE / POSITIVE** **DATE** ______________

TREATMENT:

_____ **ORAL ANTIBIOTICS** _____ **IV ANTIBIOTICS**

_____ **HIBICLENS** _____ **REFUSED ALL TREATMENT** **DATE** ______________

PRENATAL BLOOD WORK

YES / REFUSED **DATE**______________

GLUCOSE TEST

YES / REFUSED **DATE**______________

NEWBORN METABOLIC SCREENING(PKU)

YES / REFUSED **DATE**______________

HEARING SCREEN

YES / REFUSED **DATE**______________

FLU SHOT:

YES / REFUSED **DATE**______________