Holy Family
BIRTH CENTER
Birth as it was intended

Name: _____

DOB: _____

INFORMED CONSENT FOR GROUP B STREP SCREENING

Group B streptococcus (GBS) is a type of bacteria that is found in 10-30% of pregnant women. A woman with GBS in the vagina can pass it to her baby during labor and birth. Most babies who acquire GBS from their mothers do not have problems. A small number, however, will become ill; some will become seriously ill and can die from sepsis, meningitis, and/or pneumonia.

It is recommended by the American College of Obstetricians and Gynecologists (ACOG) that all pregnant women be screened (cultured) for the presence of GBS at 35-37 weeks of pregnancy. If you have any of the following, it is recommended that you receive treatment in labor:

- A positive GBS culture during current pregnancy
- A previous baby with GBS infection
- Presence of GBS in the urine during current pregnancy
- Unknown GBS status and you begin labor prior to 37 weeks
- Unknown GBS status and your water breaks 18 hours or more before birth
- Unknown GBS status and you develop a fever in labor

I have been informed about GBS testing and treatment recommendations. Initial your selection.

_____ I consent to GBS screening at 36-37 weeks of pregnancy.

_____ I DO NOT consent to GBS screening

If my GBS culture is positive, or if my status is unknown, or if I elect to decline testing

_____I consent to IV antibiotic therapy in labor

_____I consent to IV antibiotic therapy in labor if I develop one of the risk factors listed above

_____I decline all antibiotic therapy, regardless of culture results or risk factors that may develop

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I have read and understand the risks associated with GBS infection of the newborn. I take full responsibility for my health and the health of my baby. In addition, I will ensure that if my newborn shows signs of GBS infection I will immediately have him/her evaluated by a health care provider with pediatric expertise. I have had the opportunity to ask questions regarding GBS infection prevention and treatment and feel comfortable with my decision as indicated by my signature below:

Patients Signature: _____ Date: _____

CNM Signature: _____ Date: _____