Listed below, you will find a wealth of information regarding your future experience:

FAQs:

Where is Labor & Delivery?
What are the visiting hours?
Does the medical center have Wifi?
Can my birth be recorded on video?
Does the medical center have any place for family members to stay while I'm hospitalized?
What is a birth plan?
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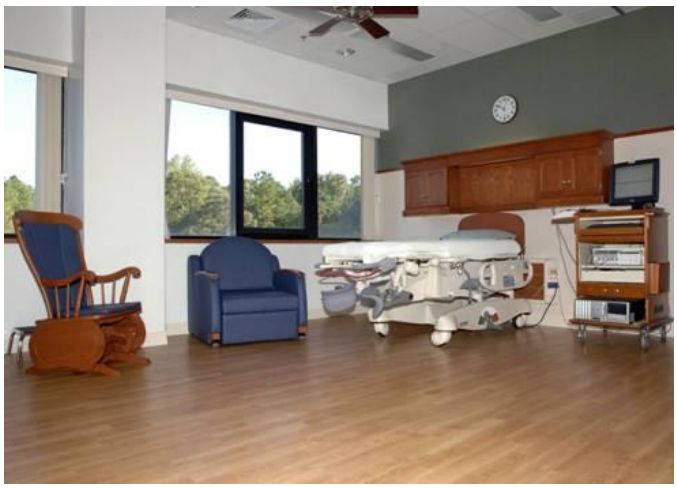
How do I enroll my new baby in DEERS?
Is my baby safe from infant abduction while at the medical center?
What takes place before we are discharged home?
What if my baby isn't ready to go home?
After I go home, what follow-up care will my baby and I receive?
Can my family and friends call the medical center for updates on my condition?
Does the medical center offer any pregnancy related health promotion classes?

Does the medical center sell any birth memory keepsakes?
I had an awesome experience, how can I say thank you?

Where is Labor & Delivery? (return to FAQs)



The Labor & Delivery Unit is located on the second floor of Naval Medical Center Camp Lejeune. It consists of 5 triage beds, 10 birthing suites, and two operating rooms. 24 hours a day, 7 days a week, the Labor & Delivery Triage Desk has a Labor & Delivery Nurse and a Provider available for women 20 weeks gestation or greater where they can be evaluated for their concerns and given the appropriate care as needed. Depending on your individual situation, you may be admitted to the medical center, reevaluated, or sent home.

Our large birthing suites offer seating for visitors, a fold out bed for an overnight guest, and a private restroom with a shower. There is also additional seating in our nearby waiting room.

What are the visiting hours? (return to FAQs)

There is no set visiting hours for Labor & Delivery or the Mother Baby Unit, as we want you and your family to share in this significant life event. However, due to safety concerns, children are not allowed to stay overnight with you in your room. We do suggest that you limit the number of guests to provide adequate rest time for you and to not disturb other patients. Children must be under the supervision of an adult other than the patient. Children who are sick or have been exposed to a communicable disease in the past two weeks should not come to visit. Every room is furnished with either a pull out bed or a second bed to allow spouses or a support person to spend the night with the mother and baby. Significant others are not permitted to sleep in the same bed with the patient. Also, if due to high patient census, you are sharing a room with another patient, your partner will not be allowed to stay the night.

Can my birth be recorded on video? (return to FAQs)

Yes, we want you to have memories of your birth and under normal circumstances we allow both video and still photography. However, during emergency situations or at the Attending Physician's discretion, we may ask that you not record.

Does the medical center have any place for family members to stay while I'm hospitalized? (return to FAQs)

Yes, Camp Lejeune is proud to offer the Fisher House which is available for family members of hospitalized patients. For more information regarding the Fisher House, click here. There are special requirements for admission into the Fisher House so please check with the Labor & Delivery staff when you are admitted.

What is a birth plan? (return to FAQs)

A birth plan is a way for you to communicate your wishes to your healthcare team who will care for you while in labor. For more information about birth plans, click here.

How do I know it's time to come to the medical center? (return to FAQs)

The Braxton Hicks contractions you may have been experiencing since the middle of your pregnancy were just occasional, irregular cramps that generally subsided. When true labor begins, the contractions start as mild, irregular cramps that become regular and more painful over time. You may feel these cramps in your back or in your upper or lower abdomen. You usually can't feel your baby move during the cramp or contraction. The contractions push the baby's head down, slowly thinning and opening the cervix. This is called effacement and dilation. False labor is when you feel the same pains, but the contractions do not open the cervix. It is not real labor, but it is real pain! Real labor dilates the cervix.

If you are preterm, pregnant with twins, or have other high-risk conditions, contact your doctor or midwife immediately if you think you might be going into labor. Any pregnant woman who experiences any of the following conditions should also contact her doctor or midwife without delay:

- Rupture of membranes (water breaking)
- Heavy vaginal bleeding
- No movement from baby
- Swelling of the face and hands
- Blurred vision
- Severe headaches
- Dizziness
- Intense stomach/abdominal pain
- Sudden weight gain (more than four pounds in a week)

Remember, L&D Triage is available for any woman 20 weeks gestation or greater and you can call 910-450-3003 or 3004 for phone advice.

What should I bring with me to the medical center? (return to FAQs)

We want you to bring anything that will make you more comfortable while at the medical center. Don't worry, if you do not bring anything, we will provide everything you need. Some

recommended items include:

- Lotion or talcum powder so your coach can give you a massage
- Tennis balls for back rubs
- Lip balm or lipstick
- Pillows
- Music: bring a portable tape/CD/MP3 player with a good variety of music selections
- Items to help pass the time: books, cards, movies
- Focal point
- Comb/brush
- Hair ties, barrettes
- Information for Red Cross message if father of the baby is deployed
- Snack bag: snack foods for coach
- Change for the vending machines
- Socks
- Slippers
- Change of clothes for support person
- Camera/video recorder and charging cord
- Baby book
- Pillow and blankets for the support person (we will provide but if your support person likes their special pillow and/or blanket)

There are a few items you cannot bring: no cooking items (crock pot, coffee pot, heat pads, etc.), no playpens for other children.

What is L&D Triage? (return to FAQs)

L&D Triage is an area, on Labor & Delivery, that is staffed by a L&D Nurse and a Provider where pregnant women, 20 weeks gestation or greater, can be evaluated 24/7 for pregnancy related concerns. We also offer advice over the phone by calling 910-450-3003/3004. If you have your medical chart in your possession, please bring it with you. If not, please call ahead and let us know you are coming so we can have your chart ready when you arrive.

Can I bring children with me to L&D Triage? (return to FAQs)

If you come to L&D Triage we ask that you do not bring children as you will be connected to a fetal monitor so we can evaluate your fetus. You will never be turned away even if you have children but there have been times when patients have come to triage for what they thought was a simple concern and ended up in the operating room for an emergency c-section.

What if I think something is wrong with my baby while I'm still pregnant? (return to FAQs)

Nobody knows yourself better than you so if you think something is wrong we want you to come see us. Our L&D Triage desk is here 24 hours a day, 7 days a week. You can call 910-450-3003 or 3004, come in to L&D Triage, or both.

What if I am considered "high risk"? (return to FAQs)

If you've been told you have a "high-risk" pregnancy, you and your baby need extra medical support to ensure you both stay as healthy as possible. Our maternal-fetal experts follow you

closely throughout your pregnancy and delivery. We believe that every woman is different, and so is her pregnancy.

We care for women who are carrying multiples (twins), who have a history of pregnancy complications (such as miscarriage, preterm delivery and cervical incompetence) or have an existing medical condition that could affect pregnancy, such as heart disease, diabetes, lupus, or seizure disorder. You should discuss your concerns with your prenatal care manager who will refer you to Maternal-Fetal Medicine if necessary.

Our Maternal-Fetal Medicine specialists, specialized ultrasonographers, midwives and nurse practitioners work together to make sure you have the best pregnancy outcome possible. We also work closely with the pediatric specialists in our Neonatal Intensive Care Unit. They offer specialized medical care for babies born with birth defects diagnosed in the womb that need immediate care after delivery.

Advanced ultrasound. We offer a wide range of advanced imaging options including targeted fetal ultrasound, fetal echocardiography (ultrasound that studies your baby's heart and blood flow), and MRI. Our ultrasonographers and Maternal-Fetal Medicine specialists are specifically trained to interpret these tests in order to detect and monitor developmental issues that can occur with your baby.

Personalized pregnancy support - We believe that every woman is different, and so is her pregnancy. Our Maternal-Fetal Medicine specialists provide both comprehensive consultation as well as complete obstetric care for high-risk patients. If you have an existing medical condition, we will work with you before you conceive to help you plan for the healthiest pregnancy and delivery possible. Our on-site nutritionist provides support for our patients who have weight or diet related issues.

What is labor? (return to FAQs)

Labor is a series of continuous, progressive contractions of the uterus, which help the cervix to open (dilate) and to thin (efface), allowing the fetus to move through the birth canal. Labor usually starts two weeks before or after the estimated date of delivery. However, no one knows exactly what triggers the onset of labor.

What is Pre-term labor? (return to FAQs)

Preterm labor is labor that begins before 37 weeks gestation. At 37 weeks gestation your baby is considered "term" and at 40 weeks gestation your baby is considered "full term." Any of the following signs may signify preterm labor:

Greater than 4 contractions in an hour that feels like abdominal cramping or intermittent low-back pain
Timing: count the time from the beginning of one contraction to the end for duration, and the beginning of one to the beginning of the next for frequency.

If you notice symptoms of pre-term labor, you should:

Empty your bladder
Alter your activity (if you are resting, begin activity; if you have been active, lie on your left side and feel your abdomen for tightening).
Drink 3-4 glasses of water.
Call the Labor & Delivery Triage (910-450-3003/3004) for further evaluation.

What are the signs of labor? (return to FAQs)

Signs of labor vary from woman to woman, as each woman experiences labor differently. Some common signs of labor may include:

- Bloody show. A small amount of mucus, slightly mixed with blood, may be expelled from the vagina indicating a woman is in labor.

- Contractions. Contractions (uterine muscle spasms) occurring at intervals of less than ten minutes are usually an indication that labor has begun. Contractions may become more frequent and severe as labor progresses.

- Rupture of amniotic sac (bag of waters). Labor sometimes begins with amniotic fluid gushing or leaking from the vagina. Women who experience a rupture of the amniotic sac should go to the medical center immediately and contact their physician or midwife. The majority of women go into labor within hours after the amniotic sac breaks. If labor still has not begun after 24 hours, a woman may be hospitalized for labor to be induced. This step is often taken to prevent infections and delivery complications.

If a woman feels unsure if labor is beginning, she should always call 910-450-3003 or 3004 for advice.

What are the different stages of labor? (Return to FAQs)

Each labor is different. However, labor typically is divided into three stages:

First Stage. This is the onset of labor to complete dilation and is divided into the **latent phase**, when contractions are becoming more frequent (usually 5 to 20 minutes apart) and somewhat stronger, and the active phase. Women can have very strong, painful contractions during the latent phase. The cervix dilates (opens approximately three or four centimeters) and effaces (thins out). Some women may not recognize that they are in labor if their contractions are mild and irregular.

The latent phase is usually the longest and least intense phase of labor. The mother-to-be may be admitted to the medical center during this phase. Pelvic exams are performed to determine the dilatation of the cervix.

The **active phase** is signaled by the dilatation of the cervix from 4 to 6 centimeters. Contractions become longer, more severe, and more frequent (usually 3 to 4 minutes apart).

The third phase is called **transition** and is the last phase. During transition, the cervix dilates an additional 3 to 5 centimeters until the cervix has dilated fully to a total of 10 centimeters. Contractions are usually very strong, lasting 60 to 90 seconds and occurring every few minutes. Most women feel the urge to push during this phase.

In most cases, the active and transition phases are shorter than the latent phase.

Second Stage. The second stage of labor begins when the cervix is completely opened and ends with the delivery of the baby. The second stage is often referred to as the "pushing" stage. During the second stage, the woman becomes actively involved by pushing the baby through the birth canal to the outside world. When the baby's head is visible at the opening of the vagina, it is called "crowning." The second stage is shorter than the first stage, and may take between 30 minutes to three hours for a woman's first pregnancy.

Third Stage. After the baby is delivered, the new mother enters the third and final stage of labor--delivery of the placenta (the organ that has nourished the baby inside of the uterus). This stage usually lasts just a few minutes up to a half-hour. This stage involves the passage of the placenta out of the uterus and through the vagina.

Each labor experience is different and the amount of time in each stage will vary.
However, most women will deliver their baby within 10 hours after being admitted if the labor is not induced. Labor is generally shorter for subsequent pregnancies.

Can my labor be induced? (Return to FAQs)

In some cases, labor has to be "induced," which is a process of stimulating labor to begin. The reasons for induction vary. Labor induction is not done before 39 weeks of pregnancy unless there is a problem. Some common reasons for induction include the following:

- The mother and/or fetus are at risk
- The pregnancy has continued too far past the due date
- The mother has preeclampsia, eclampsia, or chronic high blood pressure
- Diagnosis of poor growth of the fetus

Some common techniques of induction include the following:

- Inserting vaginal suppositories that contain prostaglandin to stimulate contractions.
- Administering an intravenous infusion of oxytocin (a hormone produced by the pituitary gland that stimulates contractions) or similar drug.
- Rupturing (artificially) the amniotic sac (bag of waters).

If you are scheduled for an induction, please read the informational page by clicking here.

What will happen when I arrive to the medical center in labor? (Return to FAQs)

When you arrive at the medical center in labor you should report to the L&D Triage desk.
The nursing staff will perform a physical exam of the abdomen to determine the size and position of the fetus and an exam of the cervix. In addition, the nursing staff will check the following:

- Blood pressure
- Weight
- Temperature
- Frequency and intensity of contractions
- Fetal heart rate
- Urine and blood samples

Often, if you are less than term, it is found that you are not in “true labor” but are having false labor. We realize the pain you are experiencing is real but important developments are still occurring in your baby. Unless there is a medical necessity, we want your pregnancy to continue until you go into labor naturally.

If you are ready to deliver your child, you will be admitted into a delivery suite where you and your baby will be continuously monitored. Intravenous fluids are sometimes given during labor. The intravenous line, a thin plastic catheter, is inserted into a vein (usually in your forearm), and can also be used to give medications. Intravenous fluids are usually given once active labor has begun and also is needed when a woman has epidural anesthesia. All patients will receive an IV even if they aren’t receiving fluids through it.

The fetus, too, is carefully monitored during labor. A monitor will be placed over your abdomen to monitor your baby's heart rate.

What are pain management options during labor? (return to FAQs)

You have many options for managing the discomforts that occur during labor and the birth of your baby. Of course we want to use the safest and most effective method of pain relief for both you and your baby. The choice will be determined by:

- Your preference
- Your health
- The health of your fetus
- Your physician's or midwife's recommendation

There are three main types of pain management for labor and birth:

- Non-medicated measures. These measures provide comfort and relieve stress, sometimes called natural childbirth. Many women learn special techniques to help them feel more comfortable and in control during labor and birth. Some of these techniques include:

  Relaxation. These techniques such as progressive relaxation, in which various muscle groups are relaxed in series, can help a woman detect tension and be better able to release that tension.

  Touch. This may include massage or light stroking to relieve tension. A jetted bath or a shower during labor may also be effective ways to relieve pain or tension. Ask your physician or midwife before taking a tub bath in labor.

  Heat or cold therapy. This is used to help relax tensed or painful areas, such as a warmed towel or a cold pack.

  Imagery. These techniques of using the mind to form mental pictures that help create relaxed feelings.

  Meditation or focused thinking. Meditation focuses on an object or task, such as breathing helps direct the mind away from the discomforts.

  Breathing. These techniques use different patterns and types of breathing to help direct the mind away from the discomforts.

  Positioning and movement. Many women find changing positions and moving around during labor helps relieve discomfort and may even speed labor along. Rocking in a rocking chair, sitting in the "Tailor sit" position, sitting on a special "birthing ball," walking, and swaying may be helpful to relieve discomfort. Your labor nurse, physician, or midwife can help you find comfortable positions that are also safe for you and your baby.

- Analgesics. These are medications to relieve pain such as Meperidine. Small amounts are generally safe during labor and are commonly used with very few complications. However, if given in large amounts or in repeated doses, analgesics can cause respiratory depression (slowing of the breathing center in the brain) in mothers and babies.

Nitrous Oxide. Nitrous oxide, or laughing gas, is a form of pain control that patients breathe in to help manage their pain. It does not stop pain, it simply makes you not care about it as much. This form of pain control is great for those patients who do not want an epidural but do want some form of pain control. The great thing about nitrous oxide is that within a couple of minutes of not using it the effects of it are worn off.

- Anesthesia. These are medications that cause loss of sensation include pudendal block, epidural anesthesia and analgesia, spinal anesthesia and analgesia, and general anesthesia.

Positioning and movement. Many women find changing positions and moving around during labor helps relieve discomfort and may even speed labor along. Rocking in a rocking chair, sitting in the "Tailor sit" position, sitting on a special "birthing ball," walking, and swaying may be helpful to relieve discomfort. Your labor nurse, physician, or midwife can help you find comfortable positions that are also safe for you and your baby.

Local block. Anesthesia injected in the perineal area--the area between the vagina and rectum-- numbs the area for repair of a tear or episiotomy after delivery

Pudendal block. A type of local anesthesia that is injected into the vaginal area (affecting the pudendal nerve) causing complete numbness in the vaginal area without affecting the contractions of the uterus. The woman can remain active in pushing the baby through the birth canal. It is used for vaginal deliveries.

Epidural anesthesia (also called an epidural block). This anesthesia involves infusing numbing medications through a thin catheter that has been inserted into the space that surrounds the spinal cord in the lower back, causing loss of sensation of the lower body. Infusions of medications may be increased or stopped as needed. This type of anesthesia is used during labor and for vaginal and cesarean deliveries. The most common complication of epidural anesthesia is low blood pressure in the mother. Because of this, most woman need to have an intravenous infusion of fluids before epidural anesthesia is given. A risk of epidural anesthesia is a postpartum headache. It may develop if the epidural needle enters the spinal canal, rather than staying in the space around the canal. The anesthesiologist will discuss the risks, benefits, and alternatives to the various methods of pain relief with the patient.

Epidural analgesia. This is sometimes called a "walking" epidural because the medication infused through the epidural is an analgesic, which relieves pain but does not numb the body and allows movement. Combinations of medications may be used in the epidural--part analgesic, part anesthetic. The most common complication of epidural analgesia is low blood pressure in the mother. This type of anesthesia is used during labor and for vaginal deliveries. A risk of epidural analgesia is a postpartum headache. It may develop if the epidural needle enters the spinal canal, rather than staying in the space around the canal. Epidural analgesia may be used for pain relief in labor and for vaginal deliveries.

Spinal anesthesia. This type of anesthesia involves injecting a single dose of the anesthetic agent directly into the spinal fluid. Spinal anesthesia acts very quickly and causes complete loss of sensation and loss of movement of the lower body. This type of anesthesia is often used for cesarean deliveries.

Spinal analgesia. This involves injecting an analgesic medication into the spinal fluid to provide pain relief without numbing. Spinal analgesia may be used in combination with epidural anesthesia or analgesia. This may be used during

labor for pain relief or for postpartum pain relief.

General anesthesia. This type of pain relief involves giving an anesthetic agent that causes the woman to go to sleep. This type of anesthesia may be used in emergency cesarean deliveries.

What are possible labor complications? (return to FAQs)

Although serious complications are rare during labor, some problems can develop during this time. Some of the more common complications include:

Fetal meconium - when the amniotic sac ruptures, the normal color of the amniotic fluid is clear. However, if the amniotic fluid is greenish or brown in color, it may indicate fetal meconium, which is normally passed after birth as the baby's first bowel movement. Meconium in the amniotic fluid may be associated with fetal distress. A woman should consult her healthcare provider immediately.

Abnormal fetal heart rate - the fetal heart rate during labor is a good indicator of how the fetus is handling the contractions of labor. The heart rate is electronically monitored during labor, with the normal range varying between 120 to 160 beats per minute. If a fetus appears to be in distress, immediate action can be taken, such as giving the mother oxygen, increasing fluids, and changing the mother's position.

Abnormal position of the fetus during birth - the normal position for the fetus during birth is head-down, facing the mother's back. However, sometimes a fetus is not in the right position, making delivery more difficult through the birth canal. There are several abnormal positions for a fetus, including the following:

- Positioned head-down but facing the mother's front
- Positioned with the face down into the mother's pelvis, instead of the top of the fetal head
- Positioned with the brow down in the mother's pelvis
- Positioned breech (where the buttocks or feet are down first in the mother's pelvis)
- Positioned with one shoulder in the mother's pelvis

Depending on the position, a healthcare provider may try to deliver the fetus as it presents itself, attempt to turn the fetus before delivery, or perform a cesarean delivery.

What happens during delivery? (return to FAQs)

Delivery is the moment when the fetus, followed by the placenta, exits the mother's body. Fathers or partners are encouraged to be actively involved in the process of childbirth by helping with relaxation techniques and breathing exercises.

Positions for delivery may vary from squatting, sitting, to semi-sitting positions (between lying down and sitting up). With semi-sitting positions, gravity can help you push your baby through the birth canal. The type of position for delivery depends on the preference of both the mother and the healthcare provider, as well as the health of the fetus.

During the delivery process, the healthcare team will continue to monitor your vital signs (i.e., blood pressure and pulse) and the fetal heart rate. The healthcare provider will examine the cervical opening to determine the position of the fetus' head and will continue to support and guide you in your pushing efforts.

Delivery can be done either vaginally or by cesarean section (C-section).

What is a vaginal delivery? (return to FAQs)

During a vaginal delivery, the healthcare provider will assist the fetus' head and chin out of the vagina when it becomes visible. Once the head is delivered, the healthcare provider exerts gentle downward traction on the head to deliver the shoulder, followed by the rest of the body. The baby rotates itself as the last movement of labor.

In some cases, the vaginal opening does not stretch enough to accommodate the fetus. It may be necessary to expedite delivery, for example, if the baby is in distress. In such cases, the healthcare provider may perform an **episiotomy** -- an incision through the vaginal wall and the perineum (the area between the thighs, extending from the anus to the vaginal opening) to help deliver the fetus. Episiotomies are not needed for every delivery and are not routinely performed.

After the delivery of the baby, you will be asked to continue to push during the next few uterine contractions to deliver the placenta. Once the placenta is delivered, any tear or episiotomy is repaired. You will usually be given oxytocin (a drug administered either by an injection into the muscles or intravenously that is used to contract the uterus) and the uterus will be massaged to help it contract, and to help prevent excessive bleeding from occurring.

What is a cesarean section (C-section)? (return to FAQs)

If a woman is unable to deliver the fetus vaginally, the fetus is delivered surgically, by performing a cesarean section. Cesarean sections are performed in an operating room. Some cesarean sections are planned and scheduled accordingly, while others may be performed as a result of complications that occur during labor.

Once the anesthesia has taken effect, an abdominal incision is made, and an opening is made in the uterus. The amniotic sac is opened, and the baby is delivered through the opening. The woman may feel some pressure and/or a pulling sensation.

Following the delivery of the baby, the healthcare provider will stitch the uterine and abdominal incision. After a cesarean or vaginal delivery, women will have some bleeding.

Are there certain conditions that make a cesarean section more likely? (return to FAQs)

There are several conditions that may make having a baby by cesarean section more likely. These include:

- Previous cesarean section
- Fetal distress
- Abnormal delivery presentation (i.e., breech, shoulder, face)
- A labor that fails to progress or does not progress normally
- Placental complications. One example is placenta previa, in which the placenta blocks the cervix. This raises the risk that the placenta will become detached too soon from the uterus.
- Twins or other multiples

What is a TOLAC? (return to FAQs)

A TOLAC, or “trial of labor after cesarean,” is when a mother wants to try to have a vaginal birth

after she has had a cesarean section and this is the first baby since her last c-section. There are multiple criteria that allow a mom to be able to TOLAC or not; discuss this with your provider. For more information about TOLAC, click "here".

What is a VBAC? (return to FAQs)

A VBAC, or “vaginal birth after cesarean,” is when a mother wants to have a vaginal birth and has already had another baby vaginally since a previous c-section. This patient’s pelvis is considered “proven” to be able to withstand the pressure of a vaginal birth and is therefore considered to be less of a risk than a TOLAC.

What care will my baby receive in the delivery room? (return to FAQs)

The birth of a baby is one of life's most wondrous moments. Few experiences compare to this event. Newborn babies have amazing abilities, yet they are completely dependent on others for feeding, warmth, and comfort.

Amazing physical changes occur with birth. When the baby is delivered, the umbilical cord is cut and clamped near the navel. This ends the baby's dependence on the placenta for oxygen and nutrition. As the baby takes its first breath, air moves into the lungs. Before birth, the lungs are not used to exchange oxygen and carbon dioxide, and need less blood supply. The fetal circulation sends most of the blood supply away from the lungs through special connections in the heart and the large blood vessels. When a baby begins to breathe air at birth, the change in pressure in the lungs helps close the fetal connections and redirect the blood flow. Now blood is pumped to the lungs to help with the exchange of oxygen and carbon dioxide. Some babies have excess amounts of fluid in their lungs. Stimulating the baby to cry by massage and stroking the skin can help bring the fluid up where it can be suctioned from the nose and mouth.

A newborn baby is wet from the amniotic fluid and can easily become cold. Drying the baby and using warm blankets and heat lamps can help prevent heat loss. A knitted hat will be placed on your baby's head. Placing a baby skin-to-skin on the mother's chest or abdomen also helps to keep the baby warm. This early skin-to-skin contact also reduces crying, improves mother-infant interaction, and helps mothers to breastfeed successfully.

Health assessments of your new baby begin immediately. One of the first checks is the Apgar test. The Apgar test is a scoring system designed by Dr. Virginia Apgar, an anesthesiologist, to evaluate the condition of the newborn at one minute and five minutes after birth. Your healthcare team provider will evaluate the following signs and assign a point value:

- Activity; muscle tone
- Pulse rate
- Grimace; reflex irritability
- Appearance; skin color
- Respiration

A score of 7 to 10 is considered normal. A score of 4 to 6 may indicate that the baby needs some resuscitative measures (oxygen) and careful monitoring. A score of 3 or below indicates that the baby requires immediate resuscitation and lifesaving techniques.

As long as everything is going normally, a member of the healthcare team will perform the following procedures:

- Measurement of the temperature, heart rate, and respiratory rate
- Measurement of weight, length, and head circumference. These measurements help determine

if a baby's weight and measurements are normal for the number of weeks of pregnancy. Small or underweight babies, as well as very large babies, may need special attention and care.
- Cord care. The baby's umbilical cord stump will have a clamp. It needs to be kept clean and dry.
- Bath. Once a baby's temperature has stabilized, the first bath can be given.
- Footprints are taken and recorded in the medical record

Before your baby leaves the delivery area, identification bracelets with identical numbers are placed on the baby, mother and spouse or support person. Babies will have two; one on the wrist and one on an ankle. These identification bands will be checked each time your baby comes or goes from your room. A security anklet will also be placed on your baby at this time to ensure your baby remains safe while at the medical center.

In the first hour or two after birth, most babies are in an alert, wide-awake phase.
This offers a wonderful opportunity for parents to get to know their new baby. A baby will often turn to the familiar sound of the mother's voice. A baby's focus of vision is best at about 8 to 12 inches--just the distance from the baby cradled in a mother's arms to her face.

This first hour or two after birth is also the best time to begin breastfeeding. Babies have an innate ability to begin nursing immediately after they are born. Although some medications and anesthesia given to the mother during labor and delivery may affect the baby's sucking ability, most healthy babies are able to breastfeed in these first few hours. This initial feeding helps stimulate breast milk production. It also causes contraction of the mother's uterus, which can help prevent excessive bleeding.

What care will my newborn receive after a cesarean delivery? (return to FAQs)

If your baby is born by a cesarean delivery, chances are good that you can be awake for the surgery. Only in rare situations will a mother require general anesthesia during your cesarean, meaning she is not conscious for the birth. Most cesarean deliveries today are done with a regional anesthetic such as an epidural or spinal. With this type of anesthesia, only part of the body is numbed for surgery, which means you are awake and able to hear and see your baby as soon as he or she is born.

A nursery nurse and a pediatric provider will assess your baby born by cesarean right after delivery which is done right near you in the operating room. Because babies born by cesarean may have difficulty clearing some of the lung fluid and mucus, extra suctioning of the nose, mouth, and throat are often needed. Occasionally, deeper suctioning in the windpipe is required.

Once your baby is evaluated, a nurse will wrap the baby warmly and bring the baby to you to see, touch and bond. Once the surgeon finishes the cesarean section, both you and your baby are moved to the recovery room where all the usual procedures such as weighing and medications are performed. If your baby needs special attention, he or she may be taken to the Neonatal Intensive Care Unit (NICU) for closes monitoring and treatment.

Many mothers think that they will not be able to breastfeed after a cesarean. This is not true. Breastfeeding can begin in the first hours of life, even right in the recovery room, just as with a vaginal delivery.

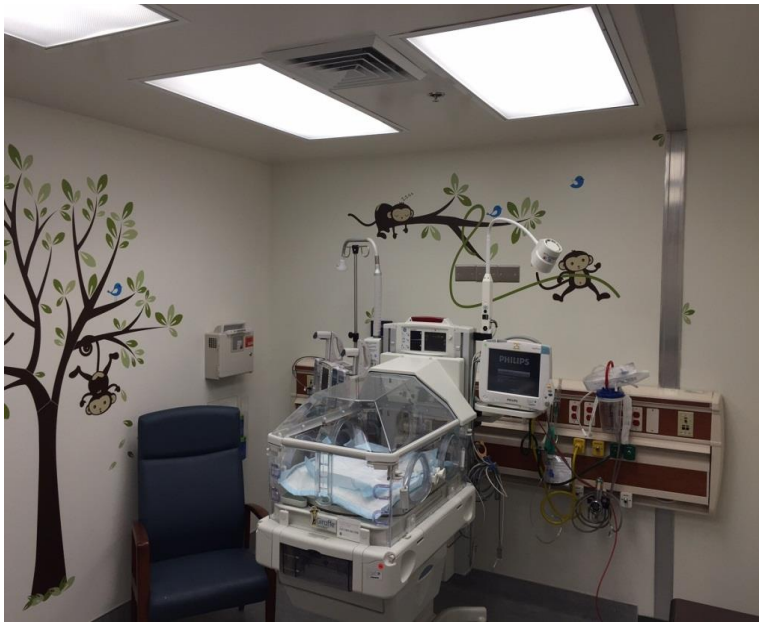
Plan to have someone stay with you during your hospital stay after a cesarean delivery as you will have quite a bit of discomfort in the first few days and will need help with the baby.

Where will my baby be cared for after delivery? (return to FAQs)

Like most facilities, we are proud to have a family centered care medical center and provide couplet care to minimize separation of your infant from your family as much as possible, unless prevented by the care needed for your baby prevents this. We recommend skin-to-skin bonding time right after delivery, and complete all of your infant care right in your arms or at the infant warmer in your room!

The only time you and your baby are separated after birth is if your baby is in need of close monitored in the NICU or if you receive general anesthesia during your c-section.

What happens if my baby has difficulty after birth? (return to FAQs)



All the baby's body systems must work together in a new way after birth. Sometimes, a baby has difficulty making the transition after delivery. Ongoing health assessments during this transition period can help determine if a baby is doing well or will need additional assistance. Ten percent of all newborns will need additional help at delivery. If there are signs that the baby is not doing well, some treatments can be done in the delivery room. The doctor or midwife and other members of the healthcare team work together to help the baby clear excess fluid and begin breathing if necessary.

Babies who may have difficulty at birth include, but are not limited to, those born prematurely, those born with a difficult delivery, and those born with birth defect(s). Fortunately for these babies, special care is available at NMCCL. Newborn babies who need intensive medical attention are admitted into a special area of the medical center called the Neonatal Intensive Care Unit (NICU). The NICU combines advanced technology and trained health professionals to provide specialized care for babies 30 weeks gestational age and above. For our tiny patients who are not sick but need additional care, the NICU provides specialized nursing care to prepare them for going home.

Infants whose medical condition requires a level that cannot be provided at Naval Medical Center Camp Lejeune may need to be transferred to another medical center in the area. Few parents expect complications of pregnancy or their baby to be born sick or premature. It is quite natural for parents to have many different emotions as they try to cope with the difficulties and stresses of a sick baby. However, it is reassuring that today's advanced technology is helping sick babies get better and go home sooner than ever before. Further, it helps to know that although separation from a baby is painful, it does not harm the relationship between mother and baby.

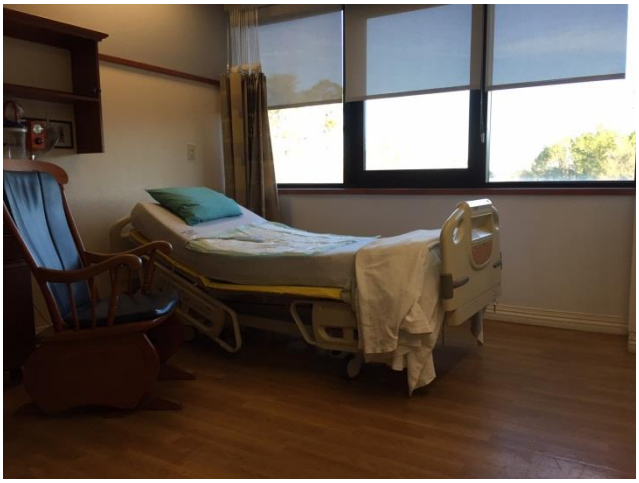
Are there specialists available if my baby has a difficult delivery? (return to FAQs)

We work closely with a team of Neonatologists that are ready at a moment's notice to manage any complications with very sick or premature newborns. Our trained, neonatal experts provide comprehensive care for premature and full-term infants who need special medical services after birth.

How long will I stay in the medical center after I deliver? (return to FAQs)

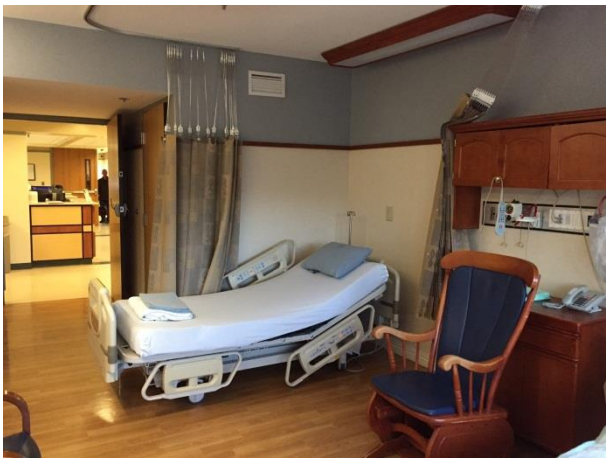
After delivering your baby you will continue to be monitored and receive pain relief, if needed. A mother giving birth vaginally will usually remain at the medical center for a couple of days; cesarean deliveries usually a little longer.

Will I stay in my delivery room the whole time? (return to FAQs)



After your delivery on Labor & Delivery, you and your baby will usually remain on L&D for at least two hours before you and your baby transfer to the Mother Baby Unit (MBU). While on MBU, our nurses will welcome you to your private room, equipped with a bed for your partner as well and a private bathroom with a shower. We will make you as comfortable as possible, orient you to the room, and educate you about all the wonderful experiences you are about to enjoy with your new family member.

During your stay, you will receive detailed instructions from your nurse on how to care for yourself and your baby when you go home. Your baby may go to the treatment room for a brief period for any minor procedures or to be assessed, as we want your room to be a safe place for your child. Afterwards, your baby will be brought back to you and you will be cared for together. Sleeping with your infant in yours or your partner's bed is not allowed. It is always best that your baby sleeps in a crib or bassinet. While we cannot prevent your baby from sleeping with you in your bed at home, we do not allow this while here and we highly recommend this not be done at home as infants have suffered irreparable harm and even death.



Your baby will have their hearing screened. The hearing test is performed sometime after eight hours of life while your baby is asleep or quiet. Your baby will also have a Newborn screening and bilirubin test while on the unit. The Newborn screening tests for 54 metabolic conditions that if not detected could result in mental retardation or death. Bilirubin is tested to check for jaundice. Circumcision is also performed prior to discharge at parent's request. If you wish your baby to be circumcised, or if you have any questions about the procedure, please speak to your baby's doctor. For more information about circumcision, please click Circumcision Handout

While you recover, tune to our 24-hour Newborn TV channel, which will give you additional helpful information about caring for your baby. Our on-site photography service is available to

provide you with newborn photos for a nominal fee.

We realize that having a baby is exciting and overwhelming. That's why these nurses are here to teach new parents what you need to know to take care of your precious infant, including bathing, feeding and changing diapers. Our nurses also care for moms, monitoring your physical and mental health and they do it all with a reassuring personal touch. Their goal is to help alleviate anxiety and discomfort and to help parents transition into their exciting new role.

Will I ever have to share a room during my stay? (return to FAQs)

We do our best to only accept the number of patients into our OB network we can safely provide care for. However, we cannot predict when that special moment will arrive and on rare occasions, when our census is unexpectedly high and we have limited room for postpartum moms, we are forced to have new mothers share rooms. You will never have to share a labor room. We know that sharing a postpartum room is not comfortable for anyone. Please know this is only done as a last resort and we try all other alternatives before resorting to this option.

What should my activity level be when first going home? (return to FAQs)

During the first few weeks, you need to take good care of yourself to rebuild your strength. Taking the following steps can help:

- Take naps when your baby naps, to compensate for lost sleep at night from getting up to feed your baby.
- Wear a supportive bra. Cold packs may help relieve breast engorgement and swelling. Warm compresses can be used to help stimulate the letdown of milk (a reflex that triggers the release of breast milk). If you choose not to breastfeed, ice packs and binding the breasts will help alleviate engorgement within a couple of days.
- If stitches were necessary during a vaginal delivery, taking warm, shallow baths (sitz baths) twice a day may relieve soreness and speed healing.
- After a cesarean section, you should keep the incision clean and dry.

What are the "baby blues?" (return to FAQs)

It is not uncommon for women to experience the "baby blues" during the first days or weeks after delivery (most commonly seen occurring suddenly on the third or fourth day after delivery). The "baby blues" are characterized by the following symptoms, although each woman may experience symptoms differently:

- Feelings of disappointment
- Crying with no known reason
- Irritability
- Impatience
- Anxiety
- Restlessness

It is common for these "baby blues" feelings to go away soon after onset and, in most cases, without treatment. These symptoms may also be present in postpartum depression. Postpartum depression is a more severe form of baby blues. Women with postpartum depression may have trouble coping with their daily tasks.

What is postpartum depression? (return to FAQs)

Much more serious and longer lasting than the "baby blues," some women experience what is clinically referred to as postpartum depression. The following are the most common symptoms of postpartum depression. However, each woman experiences these symptoms differently. Symptoms may include:

- Sadness
- Anxiety
- Hopelessness
- Fatigue or exhaustion
- Poor concentration
- Confusion
- A fear of harming the newborn or yourself
- Mood swings characterized by exaggerated highs and/or lows
- Diminished libido (sex drive)
- Feelings of guilt
- Low self-esteem
- Uncontrolled crying and with no known cause
- Over concern/over attentiveness for the newborn and/or a lack of interest for the newborn
- Appetite changes
- Sleep disturbances
- Resentment
- Memory loss
- Feelings of isolation

What causes postpartum depression? (return to FAQs)

While the exact cause for postpartum depression is unknown, it is likely that a number of different factors, such as the following, are involved:

- The changing of roles (as a spouse and new parent)
- Hormonal changes during and after delivery
- Stress
- Personal or family history of mental illness, particularly postpartum depression
- Marital strife

How is postpartum depression diagnosed? (return to FAQs)

Typical diagnostic procedures for postpartum depression include a complete medical history, physical exam and/or psychiatric evaluation. In some cases, a thyroid screening may be done to detect any hormonal or metabolic abnormalities or conditions that may serve as an underlying cause.

What is the treatment for postpartum depression? (return to FAQs)

It is important to note that most women who experience the "baby blues," postpartum depression, postpartum anxiety, and/or postpartum obsessive-compulsive disorder have never experienced these types of symptoms before, especially with such intensity. In any case, it is important for women to seek proper treatment early - not only to ensure that the newborn remains safe and properly cared for, but also so that the mother can resolve these symptoms and experience all the joys of motherhood.

Your Provider will determine a specific treatment plan for postpartum depression based on:

- Your age, overall health, and medical history
- Severity and duration of the symptoms
- Whether or not you are breastfeeding
- Tolerance for specific medications, procedures, or therapies
- You opinion or preferences

Treatment may include:

- Medication (i.e., hormonal treatments and/or antidepressants)
- Psychological treatment (may include the new mother and/or the family or spouse)
- Peer support (i.e., support groups, educational classes)
- Stress management and relaxation training
- Exercise
- Assertiveness training (Some women need to learn how to set limits with family members, in order that they do not become overwhelmed and overworked.)

Who can stay with me at the medical center? (return to FAQs)

While on Labor & Delivery we recommend that no more than 1 or 2 support people stay overnight with you during your stay. Children are permitted to visit at any time but due to safety concerns, are not permitted to stay overnight. The rooms, though quite spacious, only have sleeping arrangements for one additional person. For first time parents the stay is an opportune time to learn about baby care along side the mother. The staff is here to answer questions and will gladly re-demonstrate any care techniques you may need to see again.

While on the Mother Baby Unit, your spouse or support person is also able to stay with you. The only exception is if you are sharing a room with another patient. If so, no overnight visitors are allowed for either patient. Again, we do everything we can to prevent you having to share a room but there are times that we cannot prevent this.

For active duty spouses, you may be granted Permissive TAD. Approval of Permissive TAD, along with the length of time, is at the discretion of your command. When applying for Permissive TAD you should bring a copy of the birth certificate.

Can I take my placenta home with me? (return to FAQs)

If you desire to take your placenta home with you for burial or other religious and/or cultural tradition please communicate this with your healthcare provider. There are special precautions that we must ensure are met but this is certainly possible. You will be required to bring a cooler with you to the medical center for transporting your placenta home and you must have someone who can transport your placenta home for you within one hour post-delivery.

What lactation services are offered at Naval? (return to FAQs)

Naval Medical Center Camp Lejeune offers lactation consultant services to support new moms who want to breastfeed. Our lactation consultants are trained and certified in counseling, education and support for breastfeeding mothers.

How do we obtain a birth certificate? (return to FAQs)

A representative from our Patient Admin Department will come to your room to give you a birth certificate worksheet. Complete this as soon as possible. The forms will be collected and a typed copy will be given to you to sign prior to discharge. If additional copies of the birth certificate is

needed, please click Birth Certificate.

How do I enroll my new baby in DEERS? (return to FAQs)

DEERS, or Defense Enrollment Eligibility Reporting System, is a worldwide, computerized database of uniformed service members (sponsors), their family members, and others who are eligible for military benefits, including TRICARE. Proper registration in DEERS is the key to receiving timely and effective TRICARE benefits. All sponsors (active duty, retired, National Guard, or Reserve) are automatically registered in DEERS. However the sponsor must register eligible family members. After family members and sponsors are registered, they can update personal information such as addresses and phone numbers online. If both parents are active duty service members, then either parent may be the sponsor (you must choose one) in DEERS. When going to register your infant, make sure you take a copy of the birth certificate.

Is my baby safe from infant abduction while at the medical center? (return to FAQs)

Keeping your baby safe is a vital priority at our facility and we maintain a sophisticated security system to ensure you and your baby remain safe. Upon birth, your child will receive an electronic security anklet that prevents your baby from leaving the floor without our knowledge. This system electronically locks all exit doors on the floor when your baby is within 5 feet of the exit.

What takes place before we are discharged home? (return to FAQs)

Prior to discharge from the medical center, mothers and fathers will receive a lot of information regarding the care of their newborn. Prescribed medications for home use will be reviewed with you by a nurse as well. Babies will need to be in their car seat before leaving the medical center. You may want to bring the directions for the car seat with you in the event that you need to make adjustments to the car seat. A nurse will check to ensure your baby is properly secured prior to leaving the unit. You will also need to stop by Admissions to checkout of the medical center. For active duty mothers, this is where you initiate your convalescent leave and pick up your leave papers.

What if my baby isn't ready to go home? (return to FAQs)

For a variety of reasons, sometimes the baby isn't ready to go home as soon as the mother. Depending on the anticipated extended length of stay for the baby, we may have you room-in with your baby. Usually, it is just an additional 24 hours that the baby has to stay. Some babies have to be on antibiotics for a week or 10 days. In these cases the mother would go home and visit the baby daily. Parents must room-in for the last 24 hours of the baby's hospitalization. If your baby only has to stay a day or two extra, then you are changed to a rooming–in status. This means the mother is no longer a patient. This has implications for the mom. Due to federal law, meals, medication, and nursing care cannot be provided to non-patients. You can elect to purchase meals in advance from the cafeteria or someone can bring food to you while you room-in. You will be responsible for taking your own medication that was prescribed and dispensed to you at the time of discharge.

What if you don't want to be discharged? Discuss your options with your OB provider, but realize that insurance companies, in part, determine your length of stay in the medical center. Yes, military facilities must follow these guidelines too – we are under Tricare Management Activity. If the mother is active duty military, her convalescent leave begins the day she is discharged from the medical center. Leave paperwork is available for pick-up in the Admissions Office located

across from the Pharmacy.

After I go home, what follow-up will my baby and I receive? (return to FAQs)

Once you go home parents usually have many questions about the care of their new baby. Infants are also at risk for feeding difficulties and jaundice during the early days of life. Before you go home you will be given an appointment for a follow-up visit in our Newborn Care Clinic (NCC). This appointment is usually 1-3 days after discharge depending on when you and your baby are discharged. Our pediatricians follow the American Academy of Pediatrics guidelines. During your visit to the NCC, a Registered Nurse will evaluate your baby. He or she also assists with emotional adjustments to parenthood. The nurse will answer any questions you have about yourself or the baby. This appointment is an hour long and is scheduled before you go home. The clinic is located in our Pediatrics Department located in the modular building area in the front of the medical center. Please arrive 15 minutes prior to your appointment time.

All mothers are highly encouraged to make an appointment for their 6-week post-partum appointment. Since the appointment is six weeks after you deliver, you must call 910-450-4561 once you get home to make the appointment.

Can my family call the medical center for updates on my condition? (return to FAQs)

Due to Patient Privacy laws (HIPPA), we cannot disclose any information over the phone. All our patient rooms have a phone for your use and we suggest you designate a person to relay information to for your family and friends who would like updates.

Does the medical center offer any pregnancy related health promotion classes? (return to FAQs)

Naval Medical Center Camp Lejeune offers many classes that will not only help to better prepare you for delivery but will also help to reduce stress and anxiety and educate both your and your partner. For a list of available classes and for information on how to register, click here.

Does the medical center sell any birth memory keepsakes? (return to FAQs)

The medical center sells commemorative blue or pink infant onesies that reads “I was born at Naval Medical Center Camp Lejeune.” There is a small cost and it is available for purchase from 7:30 am to 4 pm Monday – Friday in the Referral Management Officer.

I had an awesome experience, how can I say thank you? (return to FAQs)

Naval Medical Center Camp Lejeune utilizes the Interactive Customer Evaluation (ICE) System to receive feedback. We always want to know where we can improve and we certainly like hearing about our successes. For clinical staff, we also have the Daisy Award® for Extraordinary Nurses. To learn more about the Daisy Award, please click here. If the nurse who took care of you was extraordinary and you would like to submit him or her for this award, please complete the submission form and return via mail to:

Commanding Officer
ATTN: Daisy Award Coordinator
100 Brewster Blvd
Camp Lejeune, NC 28547

Or send via email to: usn.lejeune.navmedcenclnc.list.nmccl-daisy-award-nomination@mail.mil