Parent’s Guide to the Neonatal Intensive Care Unit

Information for families whose babies are in our NICU

The Neonatal Intensive Care Unit (NICU) is a special place for babies requiring intensive nursing and medical care. Your role with your baby and with the NICU staff is very important, and we hope this brochure will help answer some of your questions. Our doctors and nurses know you can make better decisions for your baby when you understand the care he or she is receiving, and they want you to feel welcome in the NICU.
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Note: The pronouns “she/her” and “he/his” are used alternately throughout this booklet.
Welcome to the NICU

This booklet is for families whose babies are admitted to University of Washington Medical Center’s Neonatal Intensive Care Unit (NICU) for advanced nursing and medical care. We hope this information helps you better understand the special care your baby is receiving.

If your baby is born preterm (before 37 weeks of gestation) or with a serious illness that requires “high tech” medical care, the doctors may decide that he needs to be in the NICU. In this special area, the medical and nursing staff provide the sophisticated, coordinated care so vital to your child.

During this time you may wonder just where you, as the parent, fit in – and if your baby even needs you. Rest assured that all babies, even those born prematurely, recognize their parents’ voices. Your baby knows when you’re near. The familiar sound of your voice seems to help your baby do better.

As caring and considerate as the staff in the NICU are, they touch your baby to provide necessary medical care. You touch your baby because you love him, and this, like the sound of your voice, seems to reassure your infant. Your role with your baby and with the NICU staff is very, very important.

You are not underfoot when you are at your baby’s bedside. If the health care staff needs to examine your baby, they’ll tell you. Otherwise, feel welcome to be there.
When you’re not at the medical center, phone any time to see how your baby is doing. If it’s the middle of the night and you can’t sleep because you’re wondering about your baby, call and ask. Calling will often reassure you so you can get back to sleep.

Our doctors and nurses want to keep you informed about your baby. They also recognize that you can make better decisions for your infant when you understand his care.

We want you to feel welcome on our unit.

**Being with Your Baby**

Your baby needs to receive love along with medical care. The NICU nurses and doctors take care of your baby *with* you, not in place of you – you have a very important role in the care of your infant.
During your first few visits to the NICU, you may not feel comfortable doing more than looking and listening. This is a natural reaction. Gradually, you’ll feel more comfortable about getting involved in your baby’s care – talking to her, touching her, and learning to understand her needs or interpret her signals. As your baby progresses, you’ll be able to hold and rock her, and become more involved with her physical care, such as feeding, burping, bathing, temperature-taking, diapering, and dressing. You may want to bring a musical toy or clothes for your infant.

You may live some distance away or have other responsibilities that make it difficult to be with your baby frequently, but we encourage you to visit as often as possible.

We close the NICU daily for four brief periods – 7:00 to 7:30 a.m., 3:00 to 3:30 p.m., 7:00 to 7:30 p.m., and 11:00 to 11:30 p.m. – as nursing shifts change, while we share information on each baby’s condition. No visitors or non-urgent telephone calls are accepted at these times.

Closing the unit to everyone except staff during these brief times each day ensures the privacy of every family and the timely transfer of this important information.

Parents (or mother and designated support person) are welcome – and encouraged – to be with their baby at any other time.

**NICU Procedures**

For your baby’s protection, please check at the front desk before entering the NICU and follow a special hand-washing procedure, called *scrubbing*, before you touch your baby.
You and other members of your family who handle your baby will also be asked to gown (put on a special lightweight robe) \textit{each time} you visit your baby. These procedures are described in the next section.

We ask that you visit only your own baby, and not go to other babies’ bedsides. This helps protect the babies against infection and guards the privacy of other families. When accompanied by you, and with the consent of the baby’s nurse, grandparents, or the baby’s brothers and sisters may view the baby. Your baby’s nurse will help the children put on gowns and masks and cover their hands.

Please have no more than two visitors, other than parents, at your baby’s bedside at one time. Visits may be limited or temporarily denied at the discretion of the nursing staff to meet patient or NICU needs.

\textbf{Scrubbing}

The scrub sink and gowns are inside the NICU door and instructions are posted above the sink. Ask your baby’s nurse if you have questions about the scrub procedure. If you leave the NICU, you’ll need to put on a new gown and scrub again before re-entering. After you’ve scrubbed and gowned, try not to touch anything other than your baby, including your face, hair, or equipment around your baby’s bed. If you do touch something, please wash your hands again. If you feel as if you’re coming down with a cold, please ask for a mask.

Your purse or coat may be securely stored in lockers in the family waiting room. Ask for the key at the NICU front desk.
**Telephone Calls**
We ask that only parents telephone the NICU for status reports on their babies. You may call at any time, day or night, except during shift change reports (7:00 to 7:30 a.m., 3:00 to 3:30 p.m., 7:00 to 7:30 p.m., and 11:00 to 11:30 p.m.). The NICU phone number is 206-598-4606. Grandparents and others should call you to get information.

If telephone calls to the NICU are long distance for you, let your baby’s nurse know. She or he can arrange for one of the NICU staff to call you once a day.

There is a phone for essential outgoing calls in the NICU family waiting area.

**Family Waiting Area**
The family waiting area to the right of the NICU front desk is open around the clock for your convenience. There are toys to entertain your baby’s sisters and brothers, a TV, telephone, lockers, and chairs. A restroom is available just outside the unit. We’re sorry that that we’re unable to provide overnight accommodations at the medical center; if you live out of town and need information on nearby hotels, contact the NICU social worker at 206-598-4629.

**Parking**
Parking is available in the Triangle Parking Garage across from the medical center and the Surgery Pavilion Garage for UWMC patients and visitors. Parking validation is available by contacting the inpatient service representative at the front desk or talking to your baby’s nurse.
The People Involved in Your Baby’s Care

Nurses
Highly skilled nurses care for the babies in the NICU 24 hours a day. Your baby will have a team of nurses who will coordinate his care, including plans for discharge from the NICU. These nurses will try to be available to talk with you and answer your questions whenever you visit or telephone.

Nurse Practitioners
Neonatal Nurse Practitioners (NNPs) are advanced practice nurses who specialize in and devote their entire practice to intensive care of the newborn. The NNPs are members of the Medical Staff of the hospital and provide support to the entire NICU team. Your baby may be managed by the Nurse Practitioner Team under the supervision of the Attending Neonatologist. The NNPs do not rotate regularly and so are able to provide a continuous presence in the NICU.

Physicians
A team of pediatricians cares for your infant under the supervision of an attending pediatrician or neonatologist (pediatrician specializing in the care of newborns), who serves a two-week shift in the NICU. The attending physician, a faculty member of University of Washington School of Medicine, supervises all aspects of your baby’s medical care and orders tests, medications, and treatments.

Under the supervision of the attending physician, a team of fellows, residents and interns are available around the clock in the NICU to care for your baby. Residents and interns serve month-long shifts in the NICU.
Detailed information about your baby’s progress is shared daily by these physicians during “rounds.”

**Social Worker**
All parents with babies in the NICU can call on a social worker with special training and experience with parents of premature or sick infants.

The social worker can help you and other family members cope with the normal stresses of having a premature or sick baby, such as worry about the baby’s health, confusion about how the medical center works, disappointment over having delivered early, sadness at having to leave without the baby, frustration over being unable to visit as often as you would like, and financial concerns.

In addition, the social worker can provide information on community resources such as parent support groups, housing, and parenting classes.

If you haven’t been contacted by a social worker and would like to discuss some of these concerns, call 206-598-4629.

**Respiratory Therapists**
These highly skilled individuals have special training in the treatment of breathing problems, including oxygen delivery systems and use of mechanical ventilators. There is a respiratory therapist specially trained to care for infants available around the clock for NICU patients.
Physical Therapist
A pediatric physical therapist will evaluate your baby’s motor and behavioral development. When your baby is ready, the physical therapist will show you ways to hold and play with him to promote optimal growth and development.

Inpatient Service Representative (IPSR)
These front desk staff members perform and coordinate clerical and receptionist duties for the NICU.

Breast-feeding Support
Certified lactation consultants are available to answer questions about breast-feeding your premature baby, breast pumps, storing your milk, and related concerns. You can contact the lactation program by calling 206-598-4628.

When you are at UWMC, you may use one of our electric breast pumps in a private room or at your baby’s bedside. To rent an electric breast pump to use at home, call 425-462-0577 or 1-800-578-2260 (Pacific Medical Systems). This company will deliver a pump to our medical center or to your home, if you live in the Seattle/King County area. To get a list of other breast pump rental companies, call UWMC’s Lactation Services at 206-598-4628.

Some insurance companies pay for breast pump rental; prescription forms are available if needed. Ask your baby’s nurse or the lactation specialist if you have questions.
Neonatal Nutritionist
This specialized dietitian is trained in the nutritional needs of newborn babies, including premature infants. She provides ongoing assessments of your baby’s growth and nutritional status and information to the NICU staff.

Neonatal Pharmacists
These pharmacists have specific knowledge about the medications used to treat conditions affecting newborn and premature babies. They monitor medication therapy and provide other NICU team members with information to help in selecting the appropriate medications and dosages your baby may require.

If your baby needs medications for a time after discharge from the NICU, the neonatal pharmacists will help you understand what the medications are for, their possible side effects, how they are given, and what to do about medication storage and prescription refills.
Your Baby’s Special Needs

A full-term pregnancy usually lasts 40 weeks. When a baby is born before 37 weeks of gestation, he is called premature or preterm.

Don’t assume that your baby was born prematurely because of something you did or didn’t do while carrying your baby. If your pregnancy was “high risk,” your doctor may be able to explain how it was related to an early delivery. However, premature deliveries often occur for reasons that are unknown.

The Neonatal Intensive Care Nursery is specially designed to care for premature and sick babies. When your baby is admitted to the NICU, the nurses and doctors watch him closely for changes in skin color, breathing, heart rate, temperature, and blood chemistry values. Your baby may have a variety of problems that influence how long he needs to stay in the NICU.

Nutrition

Until your baby can eat by sucking from your breast or a bottle, we feed her a nutrient-rich formula and other fluids intravenously (via an IV line) or by gavage (via a soft, flexible tube passed through the nose or mouth into the stomach for each feeding).

If you want to breastfeed your baby later, start pumping your breasts on a regular basis as soon as possible after the baby is born. This will ensure that you’ll have an adequate milk supply when the baby is able to nurse. We can teach you to pump your breasts successfully and store your milk for future use, as well as answer your questions about nursing your premature baby.
When premature babies reach the gestational age of about 34 to 36 weeks, most can begin feeding from breast or bottle. A common misconception is that if a baby can suck well on a pacifier, then she should be able to start breastfeeding or feeding from a bottle. The ability to suck on a pacifier comes much earlier than the ability to feed from a nipple. Reflex sucking is seen before 28 weeks, but a coordinated “suck-swallow-breathe” pattern usually does not occur until 34 to 36 weeks of gestational age.

**Warmth**

Premature babies have very little body fat and thinner skin than full-term babies, so they can easily become chilled. We use two pieces of special equipment to make sure your baby stays warm.

The radiant warmer is a flat, open bed with heat lamps enclosed in the hood. This bed allows NICU staff to work closely with your baby while keeping him warm.

The incubator is a plastic, enclosed bed with warmed and/or moist air. The temperature inside can be regulated to meet each baby’s individual needs.

When your baby is able to be out of the incubator for a while, we can teach you how to dress him to stay warm while in your arms.
Respiratory Distress Syndrome
Some babies have respiratory distress syndrome (RDS), also referred to as hyaline membrane disease (HMD). Respiratory distress syndrome is a condition in which the baby’s immature lungs do not produce enough of a needed chemical called surfactant.

Surfactant keeps the air sacs of the lungs open during expiration (breathing out). If the air sacs are not open, exchange of oxygen (O₂) and carbon dioxide (CO₂) are decreased, and it becomes hard for your baby to breathe. Consequently, she begins to “grunt,” a sound resulting from her efforts to keep the air sacs open. She also begins to breathe faster, because many air sacs have already collapsed, so the remaining open air sacs have to take over the extra work. This rapid breathing is called tachypnea (tak-ip´-ne-ah).

Because of the lack of surfactant, the lungs are “stiff” (difficult to expand). When the respiratory muscles, such as the diaphragm, contract as the baby breathes in (inspiration), they produce negative pressure inside the chest cavity. This helps expand the lungs and pulls in the flexible chest wall, causing indentations to appear in the baby’s chest (retractions).

Despite your baby’s efforts to meet her body’s demands for more O₂ and to eliminate CO₂ through tachypnea and grunting, she will need help. She may require additional oxygen, which can be provided through a clear plastic “oxy hood” placed over her head, or by nasal prongs. If the RDS is more severe, a ventilator – a machine used to assist or breathe for the baby – may be required.
Some babies require extra oxygen or ventilator support while their lungs heal and produce surfactant. The physicians and NICU staff will monitor your infant’s progress and provide support as long as necessary.

**Sepsis**
The term “sepsis” means infection. All newborn infants, especially those who are premature, are susceptible to infection because their immune systems, which provide a natural defense against infection, are not mature at birth. As a result, an infection can enter the body and spread.

An infant can be infected in the uterus, during delivery, or in the nursery. In the nursery, infection is usually spread by skin contact. The NICU visiting procedures, such as scrubbing and gowns, are essential to decreasing the risk of infection.

**Apnea, Bradycardia, Cyanosis (ABC)**
While still inside the womb, a baby receives all his oxygen through the umbilical cord. At birth, he has to start breathing for himself. Because his brain is still maturing, he sometimes “forgets” to breathe. If this period of not breathing is 15 seconds or longer, it is called *apnea* (ap´-nee-ah) and the baby is described as apneic.

When a baby is apneic, his heart often begins to slow down. This slow heartbeat is called *bradycardia* if the baby’s heart rate drops below 100 beats per minute for 15 seconds or more.

Sometimes the baby’s skin takes on a bluish tinge, especially around the eyes and mouth. This is referred to as *cyanosis*. 
Because premature infants tend to have these apneic and cyanotic episodes, all babies admitted to the NICU are monitored for breathing and heart rate. The baby’s monitor alarm will sound if the apnea lasts 30 seconds or more or his heart rate drops below 100 beats per minute. A nurse will always come to the baby immediately and stimulate him to breathe. This returns his heart rate to normal. There is a sheet posted at your baby’s bedside where all episodes of apnea (A), bradycardia (B), and cyanosis (C) are recorded. Each time an episode occurs, a nurse checks A, B, and/or C on the chart. The nurse also writes down the time, the lowest heart rate, and how much stimulation was required to get the baby breathing again.

A “spontaneous” apnea or bradycardia means your baby began breathing or increased his heart rate on his own. “Mild” means he needed gentle stroking, his nose or mouth suctioned, or a position change. “Moderate” means the baby required a more vigorous stimulation. “Severe” refers to the nurse giving him breaths and breathing for him with an oxygen bag and oxygen. Ask your baby’s nurse to show you the ABC sheet and an oxygen bag the next time you visit.

As your baby’s brain matures, he outgrows the apnea. He’ll have fewer episodes the older he gets, until one day he won’t be at risk for even a spontaneous episode of apnea, bradycardia, or cyanosis.

If you have any questions about apnea, bradycardia, or cyanosis, ask your baby’s nurse or doctor.
Leaving the NICU

It’s an exciting day for your family – and for the NICU staff – when your baby leaves. Some babies are transferred to a hospital nursery in your community. Other babies go home. There is no strict rule about how much your baby must weigh before she can be discharged.

When your baby is ready to go home, she will no longer require any special care. For the baby, this means feeding well, gaining weight, maintaining body temperature in a crib, and being free of breathing problems.

As your baby approaches this big transition, we’ll help you learn how to care for her so you’ll feel comfortable about taking her home.

Medical Care After Discharge

If you already have a pediatrician to care for your baby once she leaves the NICU, please inform our staff. We’ll provide your doctor with progress updates while your baby is in the NICU and send a summary of the hospital course after discharge.

Your baby will need regular checkups by your pediatrician after leaving the NICU. If you need a physician, we’ll be glad to help you find one.

High-Risk Infant Follow-Up Clinic

The services of this special clinic at UW’s Center on Human Development and Disability (CHDD) are available for any infant whose development may be influenced by premature birth or other risk factors.

Infants are seen at the corrected age (see Glossary) of 4 months and then yearly until school age, unless additional visits are needed.
The High-Risk Infant Follow-Up Clinic staff includes pediatricians specializing in child development, physical and occupational therapists, audiologists (hearing specialists), psychologists, and a nutritionist.

Before your baby leaves the NICU, you’ll get a letter explaining this clinic in more detail. The High-Risk Infant Follow-Up Clinic phone number is 206-685-1255.

**Training in Infant CPR and First Aid for Choking**

Cardiopulmonary resuscitation (CPR) techniques have saved 80,000 to 105,000 lives each year since the early 1960s. These techniques improve every year through research and the efforts of the American Heart Association and the American Red Cross.

Countless people know the basics of CPR; others are certified as basic life rescuers or teachers. Through public awareness and education, CPR is becoming universally known.

You have the opportunity to learn infant CPR and first aid for choking in infants. Premature babies do not have a greater need for CPR than full-term infants; the NICU staff teach infant CPR solely to stress the need to protect and preserve all children’s lives.

CPR instruction is offered. The instruction does not officially certify you, but it does give you the basic techniques. If you’d like to learn, please ask your baby’s nurse to set a time for instruction. If you wish to become certified in adult and infant CPR, contact the American Heart Association or the American Red Cross.
Glossary of NICU Terms

**ABC**
Apnea, bradycardia, and cyanosis *(see separate entries)*.

**ABG (arterial blood gas)**
A sample of the blood from an artery that is checked for acid/base balance, oxygen, and carbon dioxide levels.

**Apnea**
A pause in breathing, often due to an immature breathing system. Apnea is common in prematures, and generally begins during the first week of life. When this occurs, the baby’s monitor sounds an alarm so the nurse can remind him to breathe.

**Bagging**
Extra breaths of oxygen given to the baby by placing a mask attached to an inflatable rubber bag over his nose and mouth. This may also be done through an ET tube if the baby is on a ventilator.

**Bili lights (phototherapy)**
A bright light placed over the baby’s incubator, used to treat jaundice. When under bili lights, the baby’s eyes are protected with soft cotton patches (“bili mask”).

**Bilirubin (“bili”)**
A normal byproduct of the breakdown of red blood cells. If bilirubin accumulates in the blood and skin, the skin takes on a yellowish tinge *(see Jaundice)*. “Bili” also refers to the blood test done to determine the level of this substance.
**BPD (bronchopulmonary dysplasia)**
This is a form of chronic lung disease of varying severity in infants, thought to be caused by the mechanical ventilation and oxygen therapy needed by some newborns. It is primarily a problem related to the severe immaturity of the lungs. The healing of lungs affected by BPD is slowed if the infant has required mechanical ventilation or oxygen for more than a few days. The repair of the lung tissue can take time, and it is common for infants to require supplemental oxygen during this period of healing.

**Bradycardia (“brady”)**
A temporary slowing of the heart rate, often occurring in association with apnea. As with apnea, the baby’s monitor will sound an alarm, and the nurse will gently stimulate him to increase his heart rate.

**CBG (capillary blood gas)**
A sample of the baby’s blood, taken from the heel, to be checked for acid/base balance, oxygen, and carbon dioxide levels.

**Chest tube**
A small plastic tube inserted through the skin into the space between the baby’s lung and chest wall, used to remove excessive air and/or fluid. A chest tube is placed in response to an air leak from the lungs (pneumothorax), and frequently remains in place for several days.

**Corrected age**
A baby’s age figured from his or her due date, rather than birth date. For example, if a baby was born 3 months early and is now 7 months old, his corrected age is 4 months.
**CPAP (continuous positive airway pressure)**
A method of providing oxygen and keeping the baby’s lungs expanded by applying pressure to the airway via a tube leading from the baby’s mouth or nose into her lungs.

**Culture**
A laboratory test used to determine whether the baby has an infection. Samples of the baby’s blood, urine, and sometimes spinal fluid are sent to the lab and watched for several days to see if any bacteria grow. If bacteria grow, the baby is said to have a positive culture. If no bacteria grow, the culture is negative.

**Cyanosis**
A bluish color temporarily seen in the skin, due to inadequate oxygenation of the blood. Cyanosis is often seen with apnea and brady-cardia, and is sometimes due to poor circulation.

**ET tube (endotracheal tube)**
A small, flexible tube placed into the wind-pipe through either the nose or the mouth and connected to a ventilator to assist the baby with breathing. The ET tube is periodically suctioned to remove mucus from the baby’s lungs.

**Gavage**
A method of feeding used for babies who are not yet strong enough to feed from bottle or breast. A soft plastic tube is placed through the mouth or nose into the stomach; fluids poured into the tube flow into the stomach by gravity.
**Hematocrit (“crit”)**
A measurement that estimates the number of red blood cells in the baby’s blood. The baby’s hematocrit often changes daily and may drop as a result of removing blood for tests. If necessary, the baby will be given a small transfusion (see Transfusion) to replace this blood.

**Incubator**
An enclosed infant bed with clear walls through which the baby is carefully observed. The temperature inside the incubator can be adjusted to meet the baby’s needs. Air is constantly circulated through a filter in the incubator.

**IV (intravenous)**
A slender tube placed in one of the baby’s veins through which fluids and medicines are given. IVs are frequently placed in the hand, foot, or scalp veins.

**Jaundice**
A condition in which bilirubin accumulates in blood and skin, giving a yellowish appearance to the skin (see Bilirubin). This is a common condition in newborn infants.

**Monitor**
Equipment used to record pulse (heart rate) and respirations. Several small sticky paper discs called leads pick up these signals. They are placed on the baby’s chest and connected by wires to the monitor. (Nothing enters the baby’s skin.)

**Murmur**
A soft “whoosh” sound heard when listening to the heart with a stethoscope. This is very common in premies. (See also PDA.)
**Nasal prongs**
A method of delivering oxygen through slender, flexible tubing placed in the nostrils.

**NIDCAP (Neonatal Individualized Developmental Care and Assessment Program)**
NIDCAP is a system used by the NICU staff for closely observing an infant’s behavior to determine how much activity, handling, noise, and light he or she can tolerate without having a decreased oxygen level or becoming upset. Once this is known, caregiving can be designed to meet the baby’s individual needs. Observations at intervals show the baby’s increasing ability to tolerate and interact with the environment.

**NPO**
The baby is not receiving anything by mouth or gavage. An IV is started to provide nutrients and water.

**Oximetry**
Continuous, non-invasive monitoring of the oxygen saturation of the blood.

**Oxy hood**
A clear plastic hood or tent placed over the baby’s head to deliver oxygen and/or humid air.

**Oxygen**
Babies having difficulty breathing may receive up to 100% oxygen (room air is 21% oxygen). The amount of oxygen required is determined by the ABG (see ABG). A constant supply of oxygen is delivered through an oxyhood or a ventilator (see Oxy hood, Ventilator).
**Parenteral nutrition**
IV fluid containing vitamins, minerals, and sugar necessary for nutrition. Parenteral nutrition is started when the baby is unable to eat for a prolonged period.

**PDA (patent ductus arteriosus)**
A heart murmur common in premature babies, caused by the connection between the pulmonary artery and the aorta not closing after birth or re-opening. The defect usually corrects itself as the baby matures.

**Periodic breathing**
A pattern of breathing in which the baby may take a few short breaths, a long breath, and a short pause. This pause is much shorter than the pause seen in apnea.

**RDS/HMD (respiratory distress syndrome/hyaline membrane disease)**
A condition affecting many premature babies, due to the lungs not being fully mature. Babies with RDS have difficulty exchanging oxygen and carbon dioxide, and frequently require extra oxygen and/or assisted ventilation.

**Retinopathy of prematurity (ROP)**
An overgrowth of the blood vessels of the retina, the membrane lining the inside of the eye that receives the image produced by the lens. Most babies with ROP usually do not experience vision damage, although a few babies may lose all or some of their vision in one or both eyes.

**Retractions**
Indentations seen in the baby’s chest wall when she is working hard to breathe.
Room air
The air around us, containing 21% oxygen.

ROP check
A special eye exam to detect retinopathy of prematurity (see Retinopathy of prematurity), performed on infants weighing less than 1500 grams (3 pounds, 5 ounces) at birth who have received oxygen.

Sepsis
An infection in the baby requiring treatment with antibiotics.

SGA (small for gestational age)
An infant who is smaller in size and weighs less than average for an infant the same age.

Suction
Removing mucus from the baby’s mouth, nose, or lungs through a soft flexible tube. Premature babies do not cough very well and need help in removing this mucus.

Transcutaneous monitor (trans Q)
A monitor used to estimate the amount of oxygen or carbon dioxide in the baby’s blood. A round electrode is placed on the skin, warming it and thus bringing blood closer to the surface so that the oxygen or carbon dioxide can be measured. The electrode is moved every 3 hours. A red mark is temporarily left on the skin; it will disappear in about 24 hours.

Transfusion
A small amount of blood given to the baby through an IV (see IV) to treat anemia (a low hematocrit – see Hematocrit).
Ultrasound
A diagnostic imaging procedure in which pictures are taken of the baby’s internal organs. Ultrasound uses high-frequency sound waves, rather than radiation, as is used in X-rays.

Umbilical artery line (IA or UAC)
A slender tube placed in the umbilical artery through which solutions are infused and blood samples drawn.

Ventilator
A machine used to assist or breathe for the baby, delivering a certain number of breaths per minute, pressure to expand the lungs, and a concentration of oxygen. The settings for the ventilator are determined by the physician from the ABG (see ABG).

Vital signs
Vital signs include temperature, pulse, respiratory rate, and sometimes blood pressure. The baby’s vital signs are frequently checked by her nurse.
Important People and Phone Numbers

NICU and Intermediate Nursery ........ 206-598-4606
Lactation specialist .......................... 206-598-4628
Social worker .................................. 206-598-4629
UW parking information .................... 206-685-1553
Metro bus information ...................... 206-553-3000

Toll-free Calling

You can now place a toll-free call to the medical center’s NICU by using our UW Automated Attendant. Just follow these four easy steps:

1. Select the number below that corresponds to the city you live in and dial.
2. When the system answers, dial the NICU at 206-598-4606.
3. Press the pound key (#).
4. Wait until the call is connected. (If the call does not connect on the first attempt, please try again.)

Aberdeen/Grayland/Westport .............. 360-612-5500
Bellingham/Everson .......................... 360-543-5500
Black Diamond/Enumclaw .................. 360-615-5500
Bermerton/Kitsap ............................. 360-525-5500
Chehalis/Centralia ............................ 360-557-5500
Coupeville/Oak Harbor ...................... 360-544-5500
East King County ............................. 425-519-5500
Everett/Monroe/Marysville ................. 425-262-5500
Hoodsport/Union ............................. 360-614-5500
Mt. Vernon ..................................... 360-542-5800
Olympia ......................................... 360-252-5500
Port Angeles/Sequim/Gardner ............. 360-504-5500
Port Townsend ............................... 360-554-5500
Seattle .......................................... 206-685-5500
Tacoma .......................................... 253-552-5500

If your city is not listed here, call 1-866-522-5589 from your home and they will provide you with a number to use. Or, go to www.washington.edu/admin/comtech/calluw.
Questions?

Neonatal Intensive Care Unit
206-598-4606

Your questions are important. Call your doctor or health care provider if you have questions or concerns. The UWMC NICU staff are also available to help at any time.