EMERGENCY CARE PLAN FOR DELIVERY

An Emergency Care Plan (ECP) is used to outline care to be provided in the event of an emergency or non-emergency abnormal condition. Midwives assist in normal childbirth and will call for emergency medical backup if the client or the midwife feels it is necessary. The ECP sets forth the physicians and hospitals to be used and documents the agreement between the midwife and the client to transport and transfer care if necessary for the mother or the baby.

Pursuant to Section 467.017, Florida Statutes, a midwife must file a copy of the ECP form that will be utilized in the practice setting with the department upon application for initial licensure and each biennial renewal. The midwife must complete the ECP form by 36 weeks or at initial consultation of pregnancy for each client and the client should keep the plan readily available to her and her family and the midwife should maintain a copy in the client's file.

I. Midwife Information:

Name:_____Business/Facility Name: _____

_____ Address: _____

_____ Cell Phone: ( )_____Pager: ( )_____Business Phone

( ) _____

II. Client Information:

Mother's Name:_____Father's Name: _____

_____ Address: _____

_____ Cell Phone: ( )_____Home Phone: ( )_____

_____EDD:_____G / P: _____

Delivery will take place in: ❑ Homebirth ❑ Birth Center ❑ Hospital

III. Client's Physician Information:

Physician's Name:_____Office Phone: ( ) _____

Address: _____

Pediatrician's Name:_____Office Phone: ( ) _____

Address: _____

IV. Emergency Transfer Hospital Information:

(List first and second option in your practice area -please check the box if the facility has NICU/Perinatal Unit)

1. Hospital Name:_____E. R. #: ( )_____L&D #: ( ) _____
   Address:_____❑ NICU ❑ Perinatal Unit
2. Hospital:_____E. R. #: ( )_____L&D #: ( ) _____
   Address:_____❑ NICU ❑ Perinatal Unit

Nearest L & D / Perinatal Unit (if different than above): _____

V. Plan for Consultation with other Health Care Providers and Emergency Transfer:

_____

_____

_____

Name of Emergency Medical Services (EMS) 911 Transport Entity: ❑ City ❑ County _____

Florida Department of Health
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PINTEREST: HealthyFla

VI. Backup Physician Arrangement (if any):

Physician Name:_____Phone: ( ) _____

Address: _____

VII. Confirmation of Midwife:

In the event complications arise during my patient's pregnancy, labor, delivery or postpartum, I will implement the Emergency Care Plan individualized for each patient accepted into my care, according to the guidelines contained herein. I will consult, refer or transfer to the appropriate health care facility as medically necessary, and provide emergency management. In order to facilitate the safe transfer of services and to provide continued supportive care to the extent that I am able, I will accompany my patient during transfer to provide relevant patient data and documentation and give report to the accepting provider.

Midwife's Signature:_____Date: _____

VIII. Confirmation of Client:

In the event of complications during my pregnancy, labor, birth or postpartum recovery, I understand that the midwife will transfer my care to the appropriate health care facility/provider. I understand that my midwife will accompany me to the hospital and continue to provide supportive care, if possible. I understand that I am responsible for any expenses incurred as a result of this transfer of care or hospitalization. I further understand that if I delay or refuse to accept emergency care as advised the midwife may discontinue her service to me. I certify that I have participated in the development of this emergency care plan and accept my responsibility for its implementation should complications or abnormal conditions arise. I have received a copy of this plan and will keep it readily available to myself and to my family.

Client's Signature:_____Date: _____

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