

EMERGENCY CARE PLAN

Client Name: _____

Address: _____

Phone(s): _____

Allergies: _____

Planned delivery location: Home Birth Center

In the event of complications during my pregnancy, labor, birth, or postpartum recovery, the Licensed Midwife will transfer my care to the appropriate medical provider/facility. Transfer will be to CMC Pineville in Pineville, NC, unless otherwise specified below.

Other medical facility: _____

Phone number: _____

Other medical provider: _____

Phone number: _____

I understand that my midwife will accompany me to the hospital and continue to provide supportive care, if possible.

I understand I am responsible for any expenses incurred as a result of this hospitalization and will make arrangements for payment of the hospital bill and other expenses related to transport.

I 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 provided input and participated in the development of this Emergency Care Plan and accept my responsibility for its implementation should complications arise.

I understand that I may request a copy of this plan.

Client Signature

Date

Midwife Signature

Date