Board *of* Nursing
Autonomous Certified Nurse Midwife
Emergency Plan-of-Care for Delivery

Pursuant to section 464.0123(3)(b), Florida Statutes, in order to provide out-of-hospital intrapartum care, a certified nurse midwife engaged in the autonomous practice of nurse midwifery must maintain a written policy for the transfer of patients needing a higher acuity of care or emergency services. The policy must prescribe and require the use of an emergency plan-of-care form, which must be signed by the patient before admission to intrapartum care.

The client should keep the plan readily available, and the midwife should maintain a copy in the client's file.

1. CERTIFIED NURSE MIDWIFE INFORMATION

Name: _____ License #: _____

Business/Facility Name: _____

Address: _____
Street City State ZIP

Business Phone: _____ Cell Phone: _____

2. PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
MM/DD/YYYY

Other Parent Name: _____

Address: _____
Street City State ZIP

Home Phone: _____ Cell Phone: _____

EDD: _____ G/P: _____

Delivery Location:	Birth Center	Homebirth	Hospital

3. PATIENT'S PHYSICIAN INFORMATION

Physician Name: _____ Business Phone: _____

Address: _____
Street City State ZIP

Pediatrician Name: _____ Business Phone: _____

Address: _____
Street City State ZIP

 Patient Name: _____

4. BACKUP PHYSICIAN ARRANGEMENT (if any)

Physician Name: _____ Business Phone: _____

Address: _____
Street City State ZIP

5. EMERGENCY TRANSFER HOSPITAL INFORMATION

List first and second hospital transfer options in your practice area. Select if the facility has a NICU and/or Perinatal Unit.

1. Hospital Name: _____ NICU Perinatal Unit

Address: _____
Street City State ZIP

Emergency Room Phone: _____ Labor and Delivery Phone: _____

2. Hospital Name: _____ NICU Perinatal Unit

Address: _____
Street City State ZIP

Emergency Room Phone: _____ Labor and Delivery Phone: _____

Nearest Labor and Delivery / Perinatal Unit (if different than above): _____

6. PLAN FOR CONSULTATION WITH OTHER HEALTH CARE PROVIDERS AND EMERGENCY TRANSFER

_____

_____

_____

Name of EMS 911 Transport Entity: _____ City County

7. CONFIRMATION OF CERTIFIED NURSE 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.

Signature: _____ Date: _____
MM/DD/YYYY

8. CONFIRMATION OF PATIENT

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.

Signature: _____ Date: _____
MM/DD/YYYY

Emergency Plan-of-Care for Delivery

To be completed if transfer of care is determined necessary.

Patient Name: _____ Date of Birth: _____
MM/DD/YYYY

CNM Name: _____ License #: _____

A. Patient condition:

_____

_____

B. Gravidity and parity of patient:

_____

_____

C. Gestational age and condition of the fetus or newborn infant:

_____

_____

D. Reasons for transfer of care:

_____

_____

_____

E. Describe the situation, relevant clinical background, assessment, and recommendations.

_____

_____

_____

_____

F. Planned mode of transport to receiving facility: _____

G. Expected time of arrival at receiving facility: _____ AM PM