Bundle of Joy Midwifery

EMERGENCY CARE PLAN

Mother _____Cell_____

Address_____

Phone _____ SS #_____DOB _____

LMP _____ EDD _____ G _____ P _____ ABO Typing _____

Father _____Cell _____

Emergency Contact _____ Relationship _____

Phone _____ Cell_____

In the event that we would need the care of a Physician please list both closest and preferred hospitals.

If my midwife deems it necessary to transport to one of the named hospitals, I agree to go. My midwife and/or associates will accompany me to the hospital and assume the role of a support person (doula) and will no longer perform clinical tasks as your midwife. She will have no control over protocols and procedures deemed necessary by the hospital staff.

Closest Hospital _____Phone #_____

Total minutes away_____ Miles _____

Route to Hospital (attach numerically listed directions, if necessary) _____

_____

_____

_____

Preferred Hospital _____Phone # _____

Address _____

Total minutes away _____ Miles _____

Route to Hospital (attach numerically listed directions, if necessary) _____

Mother _____ Date _____

Father _____ Date _____

Midwife _____ Date _____

Bundle of Joy Midwifery
179 West Smith Street, Gallatin, TN 37066
cell (615) 428-7206 office (615) 452-0600 fax (615) 452-0064
bundleofjoymidwifery@gmail.com