COLLABORATIVE MANAGEMENT AGREEMENT

Name of Licensed Midwife: _____

Address: _____

Office Phone: _____ Beeper No.: _____

Physician Name: _____

Address: _____

Office Phone: _____ Beeper No.: _____

Hospital Affiliation: _____

Address: _____

Hospital Phone: _____ ER Phone: _____ L&D Phone: _____ NU: _____

Patient's Name: _____

Address: _____

Home Phone: _____ Office Phone: _____

Age: _____ Gravida/Para: _____ EDD: _____

Patient Risk Factors: _____

_____

Rationale for Deviation from Low Risk Criteria: _____

_____

_____

Management of Care Plan: _____

_____

_____

Expected Outcome: _____

_____

Criteria to Discontinue Collaborative Agreement: _____

_____

_____

* *

On _____, _____ hereby

(Date) (Midwife's Signature)

entered into an agreement to provide collaborative prenatal/postpartum care to

_____ with _____

(Patient's Signature) (Physician's Signature)

who will direct and supervise the course of medical management as specified above.

* *

Discontinued On: _____ _____

(Date) (Patient's Signature)

_____ _____

(Midwife's Signature) (Physician's Signature)

Explanation of Discontinuation: _____

_____

_____