

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: _____