

### Hospital Transport Plan

#### PERSONAL INFORMATION

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Client address \_\_\_\_\_

Client phone-home \_\_\_\_\_ cell \_\_\_\_\_

Insurance company \_\_\_\_\_

Policy # \_\_\_\_\_

Family/friend with client \_\_\_\_\_ cell \_\_\_\_\_

#### PLACE OF TRANSPORT

Preferred hospital \_\_\_\_\_ Phone \_\_\_\_\_

Closest hospital \_\_\_\_\_ Phone \_\_\_\_\_

Your physician \_\_\_\_\_ Phone \_\_\_\_\_

Baby's physician \_\_\_\_\_ Phone \_\_\_\_\_

*The back-up hospital utilized in an emergency transport will depend on the circumstances of the transport, your insurance coverage requirements, and your preferences.*

#### MODE OF TRANSPORT

- By personal automobile if transporting for non-emergency cause, such as failure to progress in labor, moderate maternal exhaustion, or mild fetal distress. *Please have an automobile with a full tank of gas available at all times after 35 weeks gestation, in the event transport is necessary.*
- By EMS ambulance if transporting for emergency cause such as; hemorrhage, shock, serious fetal distress, newborn respiratory problems, or congenital anomalies.

#### NOTIFY THE FOLLOWING PEOPLE IF TRANSPORT IS NECESSARY

Childcare provider \_\_\_\_\_ Phone \_\_\_\_\_

Household caretaker \_\_\_\_\_ Phone \_\_\_\_\_

OTHER INFORMATION \_\_\_\_\_

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