|  |
| --- |
| **BIRTH PLAN** |

**BASIC INFORMATION**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Due date of delivery:** \_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_

**Doctor/main caregiver’s name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Location to give birth** (Check one)  
 At home  Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Birth center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who I want with me during labor:**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LABOR**

**ATMOSPHERE** (Check all applicable)

I would like it to be as quiet as possible  I would like music playing in the background

I would like the light dimmed  I would like limited staff (no students, interns, etc.)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**MONITORING THE BABY** (Check one)

I would like continuous monitoring  I would like monitoring only if the baby is in distress

I would like intermittent monitoring  I would like wireless monitoring

**POSITION** (Check one) I would like to sit  I would like to stand  I would like to lie down

I would like to be in the shower or bath  I would like to walk / move around

**PAIN MANAGEMENT** (Check One) I would like an epidural  
 Offer me pain medication if I appear to be in pain  
 Offer me pain medication only if I ask for it specifically

I am uncertain about what my preferences would be  
 I would like to use alternative pain management measures (Check all applicable)

Acupressure Acupuncture  Breathing techniques  Cold therapy

☐ Demerol ☐ Hot therapy☐ Hypnosis ☐ Massage  Meditation ☐ Reflexology

☐ Walking epidural  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**LABOR AUGMENTATION** (Check all applicable)

Performed only if baby is in distress

Performed by natural methods such as nipple stimulation

Performed by membrane stripping

Performed with prostaglandin gel

Performed with Pitocin

Performed by rupture of the membrane

Performed by stripping of the membrane

Never to include an artificial rupture of the membrane

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**DURING DELIVERY**

**POSITION** (Check one) I would like to squat  I would like to stand  I would like to lie down  I would like to be on my hands and knees  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**METHODS**

The delivery method I prefer is (Check one)**:** Vaginal  C-section  Water birth  VBAC  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Check all applicable)

I would like to be coached on when to push

I would like to push on my own as much as possible

I would like my support person to catch the baby

I would like to see my baby crown

I would like my support person to suction

Unless necessary, I do not want to use forceps

Unless necessary, I do not want to use vacuum extraction

**EPISIOTOMY** (Check one)

I would like an episiotomy than risk tearing

I would like an episiotomy only if necessary  
 I would not like an episiotomy

**EPISIOTOMY ANESTHESIA** (Check if applicable)

I would like local anesthesia

I do NOT want any anesthesia for the episiotomy

**In case of a C-SECTION** (Check all applicable)

I would like a second opinion  I would like to make sure other options have been exhausted  
 I would like to stay conscious  I would like my partner to remain with me the entire time  
 I would like the screen lowered so I can watch baby come out  
 I would like my hands left free so I can touch the baby  
 I would like the surgery explained as it happens  I would like an epidural for anesthesia  
 I would like my partner to hold the baby as soon as possible

I would like to breastfeed in the recovery room

**AFTER DELIVERY**

**I would like to hold my baby** (Check one)

Skin-to-skin contact right after delivery  After suctioning  After weighing  
 After being swaddled

**PITOCIN OR OXYTOCIN** (Check one)

I want to be given Pitocin or Oxytocin after birth

I do NOT want to be given Pitocin or Oxytocin after birth

**UMBILICAL CORD** (Check all applicable)  
 I would like my partner to cut the umbilical cord

I would like the umbilical cord to be cut only after it stops pulsating

I would like to bank the cord blood  I would like to donate the cord blood

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**PLACENTA** (Check all applicable)

I would like to see the placenta before anything is done to it

I would like the placenta discarded  I would like the placenta encapsulated

I would like to deliver the placenta myself  
 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**BREASTFEEDING** (Check one)

I plan to breastfeed

I do NOT plan to breastfeed

(Check all applicable)

I will breastfeed later  I would like to breastfeed as soon as possible  
 I would like to breastfeed before eye drops are given  
 I will feed on a schedule  I will feed on demand

**BABY’S TREATMENT**

**I would like my baby to stay in my room** (Check one)

All the time  During the day  Only when I am awake  Only for feeding  
 Only when I request it  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**I would like my baby’s medical exam** (Check all applicable)

☐ Given in my presence ☐ Given only after we’ve bonded  
☐ Given in my support person or partner’s presence

**I would like baby’s medical exam to include** (Check all applicable)

☐ Heel stick procedure ☐ Hearing screening test ☐ Hepatitis B vaccine

**Please do NOT give my baby** (Check all applicable)

☐ Vitamin K ☐ Antibiotic eye treatment ☐ Sugar water  Formula ☐ A pacifier

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**CIRCUMCISION** (Check one)

☐ I would NOT like my baby to be circumcised

☐ I would like my baby to be circumcised as soon as possible

☐ I would like my baby to be circumcised at a later time

☐ This does not apply to us

(Check all applicable)

☐ I would like him to be circumcised with anesthesia ☐ I would like to be present for the circumcision ☐ I would like my partner to be present for the circumcision

**VISITORS** (Check one)

☐ I would like visitors immediately after delivery ☐ No visitors until my baby gets his or her first feeding  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Visitor names:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Other information I would like to include about my birth plan:**

☐ I am bringing my own birthing ball

☐ I am bringing my own birthing tub

☐ I am bringing my own birthing chair or stool

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.