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|  **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.