

BIRTH PLAN

Name:

Partner/Support Person:

Birthdate:

Doula:

Due Date:

Special Considerations

Allergies, medical concerns, or notes:

Labor Preferences

Environment:

- Dim Lights
- Soft music (patient to provide)
- Open windows/natural light
- Quiet voices
- Other:

People Present:

- Partner
- Doula
- Family members
- Friends
- No visitors
- No students in room
- Other:

Pain Management:

- Breathing techniques
- Movement – walking, dancing, etc.
- Rocking Chair
- Birthing Ball
- Massage
- Hydrotherapy (bath/shower)
- Heat packs
- Squeeze combs
- IV pain medications
- Nitrous Oxide
- Epidural
- TENS units (patient to provide)
- Open to medical team suggestions
- Other:

Fetal monitoring:

- Intermittent fetal monitoring if no interventions needed and low risk labor
- Continuous fetal monitoring with Labor Inductions, Epidural, or high risk labor
- Wireless monitoring will be used as 1st option if able to trace baby this way
- Internal monitors may be discussed if needed
 - Ex. Fetal Scalp Electrode, Intrauterine Pressure Catheter.

IV Access:

- An IV access must be placed for emergencies
- Will need to be hooked to an IV line if fluids or medications are needed

Delivery Preferences

Pushing Positions:

- Upright
- Side-lying
- Squatting
- Hands and Knees
- Open to whatever is recommended
- Only quiet voices
- Cheer me on!
- Other:

An Episiotomy or a Vacuum are only done if medically necessary.

Post-Delivery Preferences

Delayed cord clamping for 1 minute is done routinely, as long as mom and baby are doing okay.

Positioning at delivery:

- Baby to my abdomen while cord pulses
- Do not put the baby directly on me

Visitors after delivery:

- Family members/Friends welcome
- No visitors please
- No students in room
- Other:

Visiting hours are per hospital policy, 11am to 8pm.

Baby Care

All babies stay in room with parents unless they need medical care in the nursery.

Feeding:

- Breastfeeding exclusively
- Formula only
- Other feeding preferences:

Newborn Procedures:

- Vitamin K shot (Need for circumcision)
- Antibiotic eye prophylaxis
- Hepatitis B vaccine
- Circumcision

I understand that circumstances may change and that my healthcare team may need to make decisions in the best interests of my health and my baby's health.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____