OFFICIAL BIRTH PLAN

for

____

Due date: __________

Partner's name: ____________________ Doctor/Midwife: ____________________
Phone number: ____________________ Phone number: ____________________

DELIVERY TYPE

☐ Vaginal ☐ C-Section ☐ VBAC ☐ Water Birth

All-natural birth without pain medication? ☐ Yes ☐ No

HEALTH INFORMATION

☐ Strep B

☐ Genital Herpes

☐ Gestational Diabetes

Number of pregnancies: _____

Other conditions that may impact labor: ____________________________

LABOR ENVIRONMENT

Names of family and friends who can be in the room during delivery: __________________

____

____

____

____

Residents or students allowed in room during labor? ☐ Yes ☐ No

Lights: ☐ Dimmed lighting ☐ Natural lighting ☐ No preference

Music: ☐ Play music of choice ☐ No music ☐ No preference

Noise level: ☐ Soft speaking ☐ No speaking ☐ No preference

PAIN MANAGEMENT

☐ Natural pain remedies. Specify: ____

☐ Administer epidural and other medications as necessary using:

☐ Intravenous (IV) line ☐ Heparin or saline lock ☐ No preference

Allergies to any medication? ☐ Yes ☐ No

If yes, provide details: ____

LABOR PREFERENCES

Movement: ☐ Encourage walking, rocking, etc. ☐ No preference

Fetal monitoring: ☐ Continuous ☐ Intermittent ☐ No preference

Labor induction: ☐ After 6 hours ☐ After 12 hours ☐ None

DELIVERY

Preferred birthing position:

☐ Semi-recline ☐ Squatting ☐ Standing upright ☐ Lying on side ☐ No preference

☐ Other: ____

I want to use a mirror to view the baby's birth: ☐ Yes ☐ No

The birth will be filmed: ☐ Yes ☐ No

AFTER DELIVERY

☐ I want skin-to-skin contact with my baby immediately after delivery

☐ I want the baby to be dried off before being brought to me

Delay cord clamping: ☐ Yes ☐ No

The umbilical cord will be cut by: ☐ Myself ☐ My partner ☐ No preference ☐ Other: _________

POST-NATAL CARE

Baby feeding: ☐ Breast feed ☐ Baby formula ☐ Combination of both

Pacifier: ☐ Yes ☐ No ☐ No preference

Circumcision: ☐ Yes ☐ No