

# Birth Preferences



## Vaginal Birth

My name: \_\_\_\_\_

Doula: \_\_\_\_\_

Partner: \_\_\_\_\_

Photographer: \_\_\_\_\_

Thank you for supporting me in the birth of my sweet baby.

Boy

Girl

Surprise

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

## Atmosphere

Wear my own clothes

Eat and Drink

Room quiet

Music

Lights dimmed

## During Labor

Intermittent fetal monitoring

Pitocin

Continuous fetal monitoring

Rupture of membranes

Minimal vaginal exams

Fetal Scalp Stimulation test

Vaginal exams when necessary

Amnionofusion

Naturally speed up labor

Hep-Lock

## Comfort Measures

Epidural (only when asked)

Position changes

Nitrous Oxide (only when asked)

Birthing combs

Sterile water injections

Counterpressure

TENS

Acupressure

Shower / Tub

Singing

Breathing techniques

Dancing

Massage

Affirmations



### Pushing Stage

- |  |  |
|--|--|
| <input type="checkbox"/> Laboring down           | <input type="checkbox"/> Warm compress on perineum       |
| <input type="checkbox"/> Self-directed pushing   | <input type="checkbox"/> Use mirror                      |
| <input type="checkbox"/> Modified direct pushing | <input type="checkbox"/> Touch baby's head               |
| <input type="checkbox"/> Directed pushing        | <input type="checkbox"/> Self or partner assist catching |
| <input type="checkbox"/> Avoid episiotomy        | <input type="checkbox"/> Push in position of my choosing |

### After Birth

- |  |  |
|--|--|
| <input type="checkbox"/> Baby placed skin to skin                  | <input type="checkbox"/> Pitocin administration    |
| <input type="checkbox"/> Delayed cord clamping until pulsing stops | <input type="checkbox"/> Physiological management  |
| <input type="checkbox"/> Golden Hour (uninterrupted)               | <input type="checkbox"/> Breast crawl              |
| <input type="checkbox"/> Keep my placenta                          | <input type="checkbox"/> Intact Core Resuscitation |
| <input type="checkbox"/> No suction for baby                       |  |

### Baby Care

- |  |   |
|--|---|
| <input type="checkbox"/> Vitamin K               | <input type="checkbox"/> If baby cannot breastfeed, syringe or cup-feed colostrum or breastmilk |
| <input type="checkbox"/> Erythromycin for eyes   | <input type="checkbox"/> No bottle or pacifier  |
| <input type="checkbox"/> Hepatitis B injection   | <input type="checkbox"/> Breastfeeding  |
| <input type="checkbox"/> Coconut oil on bottom   | <input type="checkbox"/> Formula feeding  |
| <input type="checkbox"/> No bath                 | <input type="checkbox"/> 24-hour delay to weigh baby  |
| <input type="checkbox"/> If boy, no circumcision |   |

### Personal Notes

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Provider Signature: \_\_\_\_\_

# Birth Preferences



## Cesarean Birth

My name: \_\_\_\_\_

Doula: \_\_\_\_\_

Partner: \_\_\_\_\_

Photographer: \_\_\_\_\_

Thank you for supporting me in the birth of my sweet baby.

Boy

Girl

Surprise

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

## Anesthesia

Spinal

General

## Atmosphere

Partner present

Doula present

Verbal explanations

Essential talk only

Photographs

Video

Music

## During Birth

One arm free

Clear drape

No drape / watch birth

Mirror to watch birth

Bed angled to view birth

MAC

Slow, gentle delivery

Blood transfusion

Type: \_\_\_\_\_

Iron supplements

Nausea medication



### After Birth

- |  |   |
|--|---|
| <input type="checkbox"/> Baby placed skin to skin during incision repair | <input type="checkbox"/> Breast crawl                       |
| <input type="checkbox"/> Delayed cord clamping until pulsing stops       | <input type="checkbox"/> Golden Hour during incision repair |
| <input type="checkbox"/> Intact Core Resuscitation                       | <input type="checkbox"/> Vaginal seeding                    |
| <input type="checkbox"/> Keep placenta                                   | <input type="checkbox"/> No suction for baby                |
| <input type="checkbox"/> Three Layer Anatomical Approach                 |   |

### Baby Care

- |  |   |
|--|---|
| <input type="checkbox"/> Vitamin K               | <input type="checkbox"/> If baby cannot breastfeed, syringe or cup-feed colostrum or breastmilk |
| <input type="checkbox"/> Erythromycin for eyes   | <input type="checkbox"/> No bottle or pacifier  |
| <input type="checkbox"/> Hepatitis B injection   | <input type="checkbox"/> Breastfeeding  |
| <input type="checkbox"/> Coconut oil on bottom   | <input type="checkbox"/> Formula feeding  |
| <input type="checkbox"/> No bath                 | <input type="checkbox"/> 24-hour delay to weigh baby  |
| <input type="checkbox"/> If boy, no circumcision |   |

### Personal Notes

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Provider Signature: \_\_\_\_\_