Birth Plan

Name: _____

Healthcare Provider: _____

Support Person(s): _____

Estimated Due Date: _____

Hospital / Birth Center: _____

Phone / Contact: _____

1. LABOR PREFERENCES

- [ ] I would like to move around if medically appropriate.
- [ ] I would like dim lighting and a calm environment.
- [ ] I would like music during labor.
- [ ] I would like relaxation techniques (breathing, birthing ball, etc.).
- [ ] Other preferences:

_____

_____

2. PAIN MANAGEMENT

- [ ] I would like to try natural comfort measures first.
- [ ] I am open to pain medication if needed.
- [ ] I would like an epidural.
- [ ] I would like to discuss pain management options as labor progresses.
- [ ] Other preferences:

_____

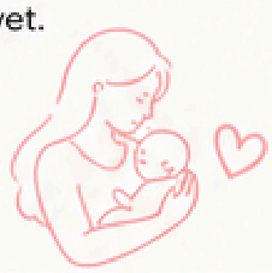
_____

3. DELIVERY PREFERENCES

- [ ] I would like my support person present during delivery.
- [ ] I would like delayed umbilical cord clamping if possible.
- [ ] I would like immediate skin-to-skin contact after birth if possible.
- [ ] I would like my partner/support person to cut the cord.
- [ ] I understand my birth plan may change if medical circumstances require it.

4. FEEDING PREFERENCES

- [ ] I plan to breastfeed.
- [ ] I plan to formula feed.
- [ ] I would like support from a lactation consultant if available.
- [ ] I have not decided yet.



5. NEWBORN CARE

- [ ] I would like my baby to stay in my room whenever possible.
- [ ] I would like routine newborn medications and screenings explained before they are given.
- [ ] I would like my support person present during newborn procedures whenever possible.

6. IF A CESAREAN BIRTH BECOMES NECESSARY

- [ ] Please explain the reason for the cesarean if time allows.
- [ ] I would like my support person with me if possible.
- [ ] I would like skin-to-skin contact in the operating or recovery room if medically appropriate.
- [ ] I would like breastfeeding support as soon as possible after birth.

Blood Type:

Comments: