

Birth plan

MOTHER'S NAME:

LOCATION:

PROVIDER:

DUE DATE:

SUPPORT TEAM

NAME & ROLE:

NAME & ROLE:

ATMOSPHERE

- ☐ DIM LIGHTNING
- ☐ LOW VOICES
- ☐ MUSIC
- ☐ ESSENTIAL OILS

PAIN MANAGEMENT

- EPIDURAL: YES ☐ NO ☐ UPON REQUEST ☐
- NUBAIN (DEMEROL): YES ☐ NO ☐ UPON REQUEST ☐
- NITROUS OXIDE: YES ☐ NO ☐ UPON REQUEST ☐
- OTHER IV PAIN MEDICATIONS: YES ☐ NO ☐ UPON REQUEST ☐

NOTES:

RESIDENTS / STUDENTS: YES ☐ NO ☐ NO PREFERENCE ☐

DELIVERY

- FOLEY BULB: YES ☐ NO ☐
- OXYTOCIN (PITOCIN): YES ☐ NO ☐
- PROSTAGLANDIN: YES ☐ NO ☐
- MEMBRANE SWEEP: YES ☐ NO ☐
- AMNIOTOMY: YES ☐ NO ☐
- CERVICAL EXAMS: YES ☐ ONLY WHEN NECESSARY ☐
- EPISIOTOMY: YES ☐ NO ☐
- FETAL MONITORING: INTERMITTENT ☐ CONTINUOUS ☐
- TRY ANY BIRTHING POSITION: YES ☐ BACK-LYING ☐

AFTER DELIVERY

- SKIN TO SKIN IMMEDIATELY: YES ☐ NO ☐
- DELAYED CORD CLAMPING: YES ☐ NO ☐
- OXYTOCIN: YES ☐ NO ☐
- FEEDING: BREAST ☐ FORMULA ☐ COMBINATION ☐
- BABY WILL: ROOM-IN ☐ NURSERY ☐ COMBINATION ☐
- ERYTHROMYCIN: YES ☐ NO ☐
- VITAMIN K: YES ☐ NO ☐
- HEPATITIS B VACCINE: YES ☐ NO ☐
- CIRCUMCISION: YES ☐ NO ☐ N/A ☐

IN THE CASE OF AN EMERGENCY C-SECTION WILL ACCOMPANY ME.

ADDITIONAL NOTES: