LABOR AND DELIVERY

ENVIRONMENT: Check all preferences:

- ❍ Please discuss confidentiality options with me.
- ❍ I wish to be able to photograph the labor and/or delivery. (Please give me the facility protocol regarding videotaping.)
- ❍ I would like dim the lighting in my room.
- ❍ I will be bringing my own music to play during labor.
- ❍ I would like to have TV and videos available.
- ❍ I prefer to wear my own clothing.
- ❍ Please help me keep visitors to a minimum.
- ❍ Please review your visiting policy with me.
- ▼ I would like my other children present for:
  - ❍ Labor
  - ❍ Delivery
- ❍ I understand that McKay-Dee hospital is a teaching hospital. During labor and delivery, I will state my wishes regarding MD Residents and nursing students being involved with my care.
- ❍ Other (please specify):_____

_____

MOBILITY:

- ❍ Ideally, I would like to be allowed freedom of movement - to walk, rock, and move as my body dictates.
- ❍ I would like to be allowed to get up to the bathroom and to change positions while laboring.
- ❍ I plan on having an epidural and as such would like to turn side to side while in bed after placement of epidural.
- ▼ In addition to the birthing bed, I am interested in having access to certain birthing equipment. If available, I would like to use:
  - ❍ Birthing ball
  - ❍ Squatting bar
  - ❍ Cordless monitoring for walking in labor
  - ❍ Chair at bedside
- ❍ I will be bringing with me:_____

_____

- ❍ Other (please specify):_____

_____

MONITORING:

- ❍ Continuous Monitoring: I desire my baby to be monitored continuously during labor and delivery.
- ❍ Intermittent Monitoring: I desire monitoring only as needed to ensure my baby is tolerating labor (this is not an option if Pitocin is being used).
- ❍ Other (please specify):_____

_____

HYDRATION:

- ❍ I would like ice and suckers.
- ❍ I would like clear liquids if possible.
- ❍ Instead of an IV drip being started immediately, I would like a heparin/saline lock to be considered.
- ❍ I prefer hydration with IV fluids as needed.
- ❍ Other (please specify):_____

_____

PAIN RELIEF: Check only one:

- ❍ PLEASE DO NOT offer me any medication for pain relief. I will let you know if I desire medicine or an epidural.
- ❍ If I appear uncomfortable, please discuss with me my options for pain relief.
- ❍ Please offer me an epidural or IV medications as soon as it is possible.
- ❍ Other (please specify):_____

_____

PAIN RELIEF OPTIONS: Check all preferences:

- ❍ Relaxation
- ❍ Positioning
- ❍ Shower
- ❍ Heat and Cold Therapy
- ❍ Massage
- ❍ IV medication
- ❍ Epidural
- ❍ Other (please specify):_____

_____

CORD CUTTING*:

- ❍ I would like my Doctor/Midwife to cut the cord.
- ❍ I desire my partner to cut the cord.
- ❍ I would like _____ to cut the cord.

* I understand that under certain circumstances, including cesarean sections, I may not have an option and my doctor/midwife will cut the cord.

DELIVERY ENVIRONMENT

- ❍ I would like to have a mirror available so that I can see my baby's head when it crowns.
- ❍ I would like a chance to touch my baby's head when it crowns.
- ❍ I would like my partner to support me and my legs as necessary during the pushing stage.
- ❍ I would appreciate having the room lights turned low for the actual delivery.
- ❍ I would like to have my baby placed on my stomach/chest immediately after delivery.
- ❍ Other (please specify):_____

_____

PUSHING: Some of these options will depend on if you are medicated, how your labor is progressing, and your baby's toleration of labor.

- ❍ I would like to have the choice of different positions.
- ❍ Even if I am fully dilated, and assuming my baby is not in distress, I would like to wait until I feel the urge to push before beginning the pushing phase.
- ❍ Please help coach me through pushing, directing me when pushing is appropriate.
- ❍ Other (please specify):_____

_____

PERINEAL CARE:

- ❍ Unless absolutely necessary, I would prefer not to have an episiotomy (a cut in the vaginal opening to assist with delivery of the head and shoulders).
- ❍ I would prefer to have an ice pack applied to the perineum following delivery to assist with swelling and pain control.
- ❍ I would like warm moist packs applied to my perineum.
- ❍ Other (please specify):_____

_____

DELIVERY OF PLACENTA/AFTERBIRTH:

- ❍ I would like the opportunity to see the placenta. Please show me the maternal and fetal sides.
- ❍ Other (please specify):_____

_____

CESAREAN DELIVERY: If I am scheduled for a cesarean delivery or if my doctor/midwife determines that a cesarean is necessary:

- ❍ It is important that my partner be present with me at all times during the birth.
- ❍ I would like to hold my baby as soon as possible in the recovery room.
- ❍ I would like to nurse my baby in the recovery room.
- ❍ Other (please specify):_____

_____

STIMULATION OF LABOR:

- ❍ I do not wish to have the amniotic membrane artificially ruptured (breaking of water) unless signs of fetal distress require internal monitoring.
- ❍ If labor is not progressing, or to increase progression of labor, I would like to have the amniotic membrane ruptured before other methods are used to augment labor.
- ❍ Please assist my labor with Pitocin if needed.
- ❍ I prefer not to have Pitocin unless absolutely necessary.
- ❍ Other (please specify):_____

_____

BABY CARE

FEEDING MY BABY:

- ❍ I plan to breast-feed my baby and would like to begin nursing as soon as possible after birth.
- ❍ Unless medically necessary, I do not wish to have any bottles given to my baby.
- ❍ I would like more information about breast-feeding.
- ❍ I would like to meet with a Lactation Consultant.
- ❍ Please provide me with information regarding the pumping and storing of breast milk.
- ❍ I DO NOT want my baby to be given a pacifier.
- ❍ I plan to bottle feed my baby.
- ❍ My preference for formula is _____
- ❍ Other (please specify):_____

_____

SEPARATION/BONDING: My preference for in-hospital infant care is:

- ❍ Full rooming-in: I prefer minimal separation from my baby.
- ❍ Delayed rooming-in: I would like my baby to be brought to me once I have rested.
- ❍ Partial rooming-in: I would like my baby to be cared for in the nursery at night, and returned to me as needed for feeding.
- ❍ Nursery care: I would like my baby to be cared for exclusively in the nursery.
- ❍ Other (please specify):_____

_____

CIRCUMCISION:

- ❍ I DO NOT want my baby to be circumcised.
- ❍ I DO NOT wish to have the circumcision performed in the hospital.
- ❍ I would like my baby to be circumcised before we go home from the hospital.
- ❍ I prefer my baby to have pain medication prior to his circumcision.
- ❍ Other (please specify):_____

_____

TRANSITIONAL BABY CARE:

- ❍ I would like my baby's post-delivery care done in the transition (observation) nursery with my support person present.
- ❍ If possible, I would like my baby's post-delivery care done in my delivery room. (This can be depend on delivery volumes.)
- ❍ Please place my baby's footprints in the book that I will be providing.
- ❍ Please provide me my baby's footprints.
- ❍ Other (please specify):_____

_____

POSTPARTUM CARE

LENGTH OF STAY:

- ❍ I would like my hospital stay to be as short as possible (24 hours or less for normal vaginal delivery).
- ❍ Please discuss with me your discharge process.
- ❍ Please discuss with me insurance information and/or financial options.
- ❍ Other (please specify):_____

_____

PAIN RELIEF:

- ❍ I prefer no pain medication following delivery.
- ▼ I prefer only oral medications for pain control.
  - ❍ Non-narcotic
  - ❍ Narcotic
- ❍ Please discuss with me all pain relief options available.
- ❍ Relaxation
- ❍ Heating pad
- ❍ Ice packs (for the first 24 hours)
- ❍ Massage
- ❍ Donut pillow
- ❍ Following delivery, I would like topical medications applied for pain control as needed.
- ❍ Other (please specify):_____

_____

ACTIVITY/HYGIENE:

- ❍ I prefer to shower as soon as possible following delivery.
- ❍ I will notify my caregiver when I am ready to shower.

ENVIRONMENT:

- ❍ I would like to have a TV and movies available.
- ❍ Please help me keep visitors to a minimum.
- ❍ Please review your visiting policy with me.
- ❍ I would like my partner to stay overnight with me.
- ❍ Other (please specify):_____

_____

ANNOUNCING MY BABY'S BIRTH:

I would like more information regarding:

- ❍ Baby Photos
- ❍ The Web Nursery
- ❍ Publication in the newspaper
- ❍ The birth certificate process

ADDITIONAL SERVICES:

I would like information on the following services:

- ❍ Education Consultant
- ❍ Childbirth education
- ❍ Discharge teaching
- ❍ Infant care
- ❍ Family education
- ❍ Social Services
- ❍ Child Development Services
- ❍ Financial / Insurance Counselor
- ❍ Dietary Specialists
- ❍ Care Managers
- ❍ Community Health Information Services
- ❍ Religious Services
- ❍ High risk obstetric services
- ❍ Neonatal intensive care services
- ❍ Adoption

The purpose of this birth plan is to educate you on a variety of childbirth options and to provide the care team with the necessary information to help the team make your experience a very special one. Our team will make every effort to follow your personalized birth plan. In some circumstances, we may not be able to meet all requests. The options discussed and requested should not be assumed to be of automatic assent on the part of your caregiver. You may make changes to your birth plan at any time.

Patient Signature_____

THIS BIRTH PLAN IS OFFERED AS AN ADDITIONAL SERVICE TO ENHANCE YOUR BIRTHING EXPERIENCE. IT IS NOT REQUIRED IN ORDER TO HAVE YOUR BABY AT MCKAY-DEE HOSPITAL.

Birth Plan for: _____

Your partner's name:_____

Address: _____

Phone: _____

Labor support person's (coach) name:_____

Your due date: _____

Name of your Doctor/Midwife: _____

Name of your baby's doctor/pediatrician: _____

Phone Number: _____

THE BIRTH PLAN INCLUDES A COMPLIMENTARY FACILITY TOUR AND PERSONALIZED DISCUSSION WITH A REGISTERED NURSE. IF DESIRED, PLEASE CALL 801.387.4666 FOR AN APPOINTMENT.

MOTHER'S CHOICE BIRTH PLAN

Intermountain McKay-Dee Hospital Center
Healing for Life™

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