MY BIRTH PLAN

BIRTH PLAN FOR:

_____

PARTNER'S NAME:

_____

DUE DATE:

_____

NAME OF YOUR DOCTOR/MIDWIFE:

_____

NAME OF YOUR BABY'S DOCTOR:

_____

INTRODUCTION

This Birth Plan booklet is offered as a tool to help you prepare for your birthing experience at Logan Regional Hospital. It is not required in order to have your baby, but it will help you think about all of the steps in the delivery process before your big day.

You can use this booklet as a guide for your childbirth care team. It will provide them with necessary information to help make your experience run as smoothly as possible. The childbirth team will make every effort to follow your plan as outlined. However, to ensure the best practice and safety for you and your baby it may not be possible to meet all of your requests.

You can change your Birth Plan at any time, just as your childbirth care team may need to change your plan to ensure safety and best practices for you and your baby.

ENVIRONMENT

Check all preferences:

- ○ Please discuss confidentiality options with me.
- ○ If circumstance permits under Intermountain policy, I wish to be able to video tape the labor and/or delivery.
- ○ I would like dim lighting in my room.
- ○ I will be bringing my own music to play during labor.
- ○ 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: (Availability is contingent upon seasonal visiting restrictions)
  - ○ Labor
  - ○ Delivery
- ○ I understand that Logan Regional Hospital is a teaching hospital. During labor and deliver, I will state my wishes regarding nursing students being involved with my care.
- ○ Other (please specify)

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COMMUNICATION

- ○ I would like all necessary communication to be in quiet voices and between contractions so I can remain focused on birthing experience.
- ○ When possible, please minimize interruptions by grouping care together.
- ○ When possible, I would like all questions to be directed to my partner or labor support person, so I am able to remain focused during my labor.
- ○ Other (please specify)

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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.
- ○ Other (please specify)

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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)

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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 saline lock to be considered.
- ○ I prefer hydration with IV fluids as needed.
- ○ Other (please specify)

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LABOR

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.
- ○ To avoid the use of Pitocin, I would like to have the opportunity to use natural methods of labor enhancement, if needed. Please direct me on how to do this.
  - ○ Walking
  - ○ Position changes
  - ○ Nipple stimulation
  - ○ Artificial rupture of membranes by physician
- ○ Please assist my labor with Pitocin if needed.
- ○ I prefer not to have Pitocin unless absolutely necessary.
- ○ Other (please specify)

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DISCOMFORT MANAGEMENT

- ○ PLEASE DO NOT offer me any medication for discomfort management. I will let you know if I desire medicine or an epidural.
- ○ I plan to use the following birthing techniques:
  - ○ Hypnobirthing
  - ○ Bradley
  - ○ Lamaze
  - ○ Other: _____
- ○ If I appear uncomfortable, please discuss with me my options for relief.
- ○ Please offer me an epidural or IV medications when possible.
- ○ Other (please specify)

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COMFORT OPTIONS

Check all preferences:

- ○ Relaxation
- ○ Positioning
- ○ Birthing ball
- ○ Squatting bar
- ○ Rocking chair
- ○ Hydrotherapy tub
- ○ Shower heat and cold therapy
- ○ Massage
- ○ IV medication
- ○ Epidural
- ○ Music therapy

- ○ I would like to limit vaginal exams to as few as necessary
- ○ Other (please specify)

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ENVIRONMENT

- I would like to have a mirror available so that I can see my baby's head when it crowns.
- I would like to limit vaginal exams to as few as necessary.
- 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 directly on my stomach / chest immediately after delivery. (Immediate skin to skin)
- I would like to have my baby placed directly on my stomach / chest after the baby has been assessed and dried. (Delayed skin to skin)
- I would like cordless (telemetry) monitoring for walking in labor.
- Other (please specify)

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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.
- I would like to have the staff refrain from talking or directing me while I labor down my baby so I can concentrate on following my body's lead during the pushing phase.
- Please help coach me through pushing, directing me when pushing is appropriate.
- Other (please specify)

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CORD CUTTING

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

- 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 would like the cord clamping to be delayed until the cord stops pulsating. (Please discuss this with medical provider prior to labor and delivery.)

DELIVERY OF PLACENTA/AFTERBIRTH

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

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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 discomfort.
- Other (please specify)

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DELIVERY

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 request that the conversation during the surgery is respectful of the important event taking place, the birth of my baby.
- If possible, I would like to see my baby be "born" during the surgery.
- I would like to hold my baby skin to skin as soon as possible in the recovery room.
- If I am not able to perform skin to skin bonding during C/S recovery, I would like my partner to perform this task.
- I would like to breastfeed my baby in the recovery room.
- Other (please specify)

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POSTPARTUM CARE

FEEDING MY BABY

- Please allow plenty of uninterrupted time following delivery for my baby to do newborn self-attachment. (baby crawls to breast and attaches on own)
- Unless medically necessary, I do not wish to have any bottles given to my baby.
- I would like more information about breastfeeding.
- 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.
- Other (please specify)

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SEPARATION/BONDING

My preference for in-hospital infant care is:

- ○ I would like me or my partner to be present with our baby for all procedures.
- ○ I prefer minimal separation from my baby.
- ○ I would like my infant's lab draws in my room regardless of time of day.
- ○ I would like my infant's lab draws done in the nursery.
- ○ I will notify staff when I wish to have my baby in the newborn nursery.
- ○ Other (please specify)

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ENVIRONMENT

- ○ 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.
- ○ When possible, please minimize interruptions by grouping care together.
- ○ Other (please specify)

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CIRCUMCISION

- ○ I would like more information about circumcision.
- ○ I DO NOT want my baby to be circumcised.
- ○ I would like my baby to be circumcised before we go home from the hospital.
- ○ Other (please specify)

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LENGTH OF STAY

- ○ I would like my hospital stay to be as short as possible (24 hours for normal vaginal delivery, 48 hours for Cesarean Section).
- ○ Please discuss with me insurance information and/or financial options.
- ○ Other (please specify)

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ADDITIONAL SERVICES

DISCOMFORT MANAGEMENT

- Please discuss with me all discomfort management options available.
  - Relaxation
  - Heating pad
  - Ice packs (for the first 24 hours)
  - Massage
  - Air pillow (donut)
  - Positioning
  - Topical medications applied for discomfort as needed.
  - Oral medications for pain control
- I prefer no pain medication following delivery.
- Other (please specify)

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ADDITIONAL INFORMATION

- Please discuss the following information with me.
  - Childbirth education
  - Discharge teaching
  - Infant care
  - Family education
  - Social services
  - Child development services
  - Financial / insurance counselor
  - Dietary specialists
  - Community health information services
  - Religious services
  - High risk obstetric services

ADDITIONAL INFORMATION CONTINUED

- Neonatal care unit
- Adoption


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