



# Birth Plan Template

## Your Details

Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Birth Partner's Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Due Date: \_\_\_\_\_

Name of obstetrician / midwife: \_\_\_\_\_

Other birth-support (doula/other family): \_\_\_\_\_

### Where do you want to give birth?

- Hospital: \_\_\_\_\_
- Birth Centre: \_\_\_\_\_
- At home
- Not sure yet

## Labour & Birth

### Environment

- Dim lights
- Aromatherapy oils
- OK to have training medical staff observe labour & birth
- Other: \_\_\_\_\_
- Quiet music
- Wear my own clothes

### Mobility during labour

- I would like to keep active during labour if possible (walking, fitball, etc.)
- Mobility is not important to me

### Relaxation and comfort during labour

- Massage
- Shower
- Bean bag
- Acupressure
- Other: \_\_\_\_\_
- Bath
- Fit ball
- Hot towels
- Hypnotherapy

### Do you want to use any special facilities?

- Birthing pool
- Other: \_\_\_\_\_

## Position(s) for labour & birth

Tick as many as you like - underline preferred birth position

- |                                      |                                      |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Walking     | <input type="checkbox"/> Standing    |
| <input type="checkbox"/> Squatting   | <input type="checkbox"/> Sitting     |
| <input type="checkbox"/> Kneeling    | <input type="checkbox"/> Lying down  |
| <input type="checkbox"/> Birth Stool | <input type="checkbox"/> Other _____ |

## Foetal Monitoring

- Continuous monitoring (will mean limited mobility)
- Intermittent monitoring
- No monitoring - except in emergency situations

## Vaginal / Cervix Examinations

- I would like minimal examinations
- I am happy for examinations as deemed necessary by medical staff
- No monitoring - except in emergency situations

## Pain Relief

- Do not offer; I will ask if I want pain relief
- Offer if I appear uncomfortable
- Offer as soon as possible

## Medical pain relief options

Number any acceptable options in order of preference

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> I would like to try to manage without medical pain relief options |                                      |
| <input type="checkbox"/> Gas / Air   | <input type="checkbox"/> Pethidine   |
| <input type="checkbox"/> Epidural  | <input type="checkbox"/> Other _____ |

## Rupturing of the amniotic sac

- I prefer my amniotic sac be allowed to rupture on its own

## Episiotomy

- I do not want an episiotomy unless there is an emergency situation
- I would like an episiotomy to reduce the risk of tearing

## Delivery

- I would like to touch baby's head when it crowns
- I would like a mirror available to view pushing/crowning/birth

## Immediately following delivery

Tick as many as you wish

- I want baby placed on my chest immediately after birth
- Please delay cord clamping and cutting until pulsating ceases
- I would like my birth partner to cut the cord
- I would like to cut the cord
- Birth partner does not want to cut the cord
- I would like to hold the baby while the placenta is delivered
- I do not want an injection to assist with placenta delivery
- I would like the baby to be examined in my presence
- If the baby cannot be examined in my presence, I would like my birth-partner to remain with the baby at all times
- I want to donate cord blood to the public cord blood bank (if service is available)
- I want to bank cord blood privately

## Assisted delivery

If additional medical assistance is required for the birth, I would prefer:

- Assisted delivery - forceps
- Assisted delivery - ventouse
- Caesarean section

## Caesarean

In the event that a cesarean section is deemed necessary, I would like the following:

- Birth partner present
- Photos / video
- I would like the procedure described as it is happening
- Other: \_\_\_\_\_
- Other support present
- Screen lowered at delivery

## Baby Care

### Feeding Baby

- I wish to breastfeed exclusively
- I wish to breastfeed, but formula supplementation is acceptable
- I wish to formula feed
- I do not want baby to be given a pacifier
- I would like to meet with a lactation consultant

### Vitamin K

- I would like my baby to have the single injection of Vitamin K
- I would like my baby to have oral Vitamin K
- I do not want my baby to have Vitamin K

### Hepatitis B

- I would like my baby to be vaccinated with Hepatitis B vaccine before discharge

### Any Special Dietary Requirements for the new Mum

### Any other special needs for new Mum and/or birth partner (language, religion, disability, etc)

### Length of stay in hospital

- I would like to have as short a stay as possible in hospital
- I would like to stay in hospital for 1-2 days after the birth
- I would like to stay in hospital for more than 2 days after the birth

### In the event that baby requires special care due to trauma or illness

- I would like to breastfeed/pump breast milk
- Birth partner will accompany baby if transferred to another hospital
- I would like to be transferred to baby's hospital

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Healthcare Provider's Name: \_\_\_\_\_

Healthcare Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_