
Birth Plan

Name: _____
Partner / Support Person(s): _____
Estimated Due Date: _____
Care Provider: _____
Birth Location: _____
Contact Number: _____

My Birth Preferences

This plan reflects my preferences at this time. I understand birth can be unpredictable and trust my care team to support a safe and healthy delivery for baby and me.

Labor Environment

- ☐ Dim lighting
- ☐ Quiet room
- ☐ Music (type: _____)
- ☐ Minimal interruptions
- ☐ Limit people coming in/out
- ☐ Partner/support person present at all times
- ☐ Other: _____

Labor Support & Comfort Measures

I would like support with:

- ☐ Freedom to move and change positions
- ☐ Use of shower or tub
- ☐ Birth ball / peanut ball

- ☐ Walking during labor
- ☐ Breathing techniques
- ☐ Massage / counter-pressure
- ☐ Heat or cold packs
- ☐ Visualization / guided relaxation
- ☐ Verbal encouragement
- ☐ Doula present
- ☐ Other: _____

Pain Management Preferences

- **I prefer to:**
  ☐ Labor without medical pain medication
  ☐ Use pain medication if needed
  ☐ Decide during labor

- **Options I am open to:**
  ☐ Epidural
  ☐ IV pain medication
  ☐ Nitrous oxide
  ☐ Other: _____

Labor Interventions

If possible, I would prefer:

- ☐ To avoid labor augmentation (Pitocin) unless medically necessary
- ☐ Artificial rupture of membranes only if needed
- ☐ Continuous fetal monitoring only if indicated
- ☐ Intermittent monitoring
- ☐ Clear explanations before any intervention
- ☐ Time to ask questions before decisions are made

Pushing & Birth

- ☐ Spontaneous, mother-guided pushing

- ☐ Coached pushing
- ☐ Upright or alternative positions
- ☐ Avoid directed breath-holding if possible

I would like to avoid, if possible:

- ☐ Episiotomy
- ☐ Vacuum or forceps

Birth Preferences

- Who catches the baby (if possible): _____
- ☐ Mirror available
- ☐ Hands-off approach if safe
- ☐ Announce baby's sex at birth
- ☐ Delayed cord clamping
- Who cuts the cord: _____

Immediately After Birth

- ☐ Immediate skin-to-skin with birthing parent
- ☐ Delay routine procedures while bonding
- ☐ Partner skin-to-skin if parent unavailable

Newborn Care

- ☐ Breastfeeding
- ☐ Chestfeeding
- ☐ Formula feeding
- ☐ Combination feeding

For baby, I prefer:

- ☐ Vitamin K injection
- ☐ Vitamin K oral
- ☐ Decline Vitamin K
- ☐ Hepatitis B vaccine

- ☐ Eye ointment
- ☐ Delayed procedures when possible

If a Cesarean Becomes Necessary

If possible, I would like:

- ☐ Clear explanation before surgery
- ☐ Partner/support person present
- ☐ Gentle cesarean (lowered drape or view)
- ☐ Immediate or early skin-to-skin
- ☐ Baby to remain with me/partner

Postpartum Preferences

- ☐ Lactation support as soon as possible
- ☐ Minimal separation from baby
- ☐ Rooming-in
- ☐ Education before newborn procedures
- ☐ Mental health resources if needed

Additional Notes / Requests

Signature: _____ Date: _____