

BIRTH PLAN

Prepared by: [BIRTHING PARENT S FULL LEGAL NAME] (she/her) **Date prepared:** **Estimated due date:** **Planned birth location:** [PLANNED BIRTH FACILITY LOCATION], [STATE] **Primary provider:** [OB MIDWIFE PRIMARY PROVIDER NAME]

To my care team: This birth plan reflects my informed preferences for labor, delivery, and newborn care. It is not a contract and it is not a refusal of medical care in a genuine emergency. I understand that clinical judgment may require deviation from these preferences, and I ask that, wherever time and safety permit, I be informed of the reason and given the opportunity to give or withhold informed consent before any intervention. Preferences not reached by this document should default to the provider's standard of care under applicable professional guidelines.

Patient Information

| Field | Detail | |---|---| | Name | [BIRTHING PARENT S FULL LEGAL NAME] | | Date of birth | | | Address | [ADDRESS] | | Phone | | | Preferred language | English | | Blood type | Not specified | | GBS status | Unknown | | Allergies | None known | | Current medications | Prenatal vitamins | | Relevant medical history | None | | Prior births | None | | Emergency contact | See support persons below |

Support Team

- **Partner / co-parent:** None designated
- **Other support persons:** None

HIPAA Authorization

Pursuant to 45 C.F.R. §§ 164.508 and 164.510, I authorize the care team to disclose my protected health information, and the protected health information of my newborn, to my partner and the support persons named above, for purposes of coordinating my care and providing updates during labor, delivery, and the postpartum stay. This authorization may be revoked by me in writing at any time.

Labor Preferences — Hospital Delivery

1. Environment and Movement

- **Freedom of movement:** Free Movement.
- **Environment:** Dim lighting, quiet voices, personal music playlist, minimal non-essential staff in the room.

- **Non-pharmacologic comfort measures I want available:** Hydrotherapy, Position Changes, Birthing Ball, Massage, Breathing.

2. Monitoring, IV, and Intake

- **Fetal monitoring:** Intermittent.
- **IV / hep-lock:** Hep Lock.
- **Oral intake:** Light Food And Fluids.
- **Cervical exams:** Minimize.

3. Induction and Augmentation

- **Induction:** Avoid Unless Medical.
- **Augmentation (Pitocin / amniotomy):** Discuss First.

4. Pain Management

- **Plan:** Flexible.
- **Offering medication:** Please do not offer pain medication unless I specifically request it. I will ask if I want it.

5. Delivery

- **Pushing position:** Position Of Choice.
- **Pushing style:** Spontaneous.
- **Episiotomy:** Avoid.
- **Vacuum / forceps:** Discuss First.
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- **Who catches / receives baby:** Provider.
- **Umbilical cord clamping:** Delayed.
- **Cord cutter:** Partner.
- **Placenta:** Hospital Disposal.

6. If Cesarean Becomes Necessary

If a cesarean becomes medically necessary, I want to be fully informed before consent, have my partner present, request a clear drape and delayed cord clamping where safe, and hold my baby skin-to-skin in the OR as soon as stable.

If a cesarean is performed, where clinically safe I request: a gentle / family-centered cesarean; a clear drape; arms free; EKG leads placed on back/sides to keep my chest clear for skin-to-skin; immediate skin-

to-skin in the OR once baby is stable; my partner present in the OR; and delayed cord clamping where safe for baby.

Newborn Care and Procedures

| Procedure | My election | |---|---| | Immediate skin-to-skin | Yes — delay all non-urgent procedures | | Delay first bath 24+ hours | Yes (WHO recommendation) | | Rooming-in | Yes — baby stays with me | | Feeding plan | Breastfeeding | | Vitamin K prophylaxis | Accept Im | | Erythromycin eye ointment | Accept | | Hepatitis B vaccine at birth | Accept | | State newborn metabolic screening | Accept | | Newborn hearing screening | Accept | | CCHD pulse-oximetry screening | Accept | | Circumcision | Not Applicable | | Cord blood banking | None |

Feeding

My feeding plan is **Breastfeeding**. **Please do not offer formula, bottles, artificial nipples, or pacifiers to my baby without my explicit consent.** If supplementation becomes medically necessary, please discuss with me first and use cup, spoon, or syringe feeding where feasible. I request an in-hospital lactation consultant visit.

Newborn Metabolic Screening

I consent to the state-mandated newborn metabolic (heel-stick) screening panel for [STATE].

Decision-Making and Emergencies

If I am temporarily unable to make decisions, decisions should be made in the following order:

1. **My partner named above, in consultation with the care team**
2. If unavailable, the emergency contact.
3. Otherwise, the standard of care under the judgment of the attending provider.

If an emergency arises, I understand that the clinical team may act immediately to preserve my life and my baby's life. I trust that where time permits, the team will seek my or my decision-maker's informed consent.

If baby requires NICU care: If baby must go to the NICU, one parent should accompany baby at all times where possible; I wish to provide colostrum/breast milk and practice skin-to-skin as soon as baby's condition allows.

Photography and Observers

- **Photography / video:** Yes No Staff Faces.

- **Students / residents / observers:** I do **not** consent to the presence of students, residents, or observers who are not part of my direct care team. Please identify any learner before entry and obtain my consent.
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Acknowledgments

I acknowledge that:

1. This birth plan represents my **preferences**, not a demand for particular medical care or a refusal of life-saving intervention in a genuine emergency.
2. I have discussed the material elements of this plan with my provider, **[OB MIDWIFE PRIMARY PROVIDER NAME]**.
3. I accept that the course of labor is unpredictable and that clinical necessity may require deviation from this plan.
4. Where my elections require signed refusal forms under facility policy or state law, I will execute those forms at admission.
5. This document is my current and considered plan as of ****.

Signature

Birthing Parent

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Copies provided to: [BIRTHING PARENT S FULL LEGAL NAME]; [OB MIDWIFE PRIMARY PROVIDER NAME]; [PLANNED BIRTH FACILITY LOCATION] admissions / labor & delivery chart; .