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
- ☐ Quiet music
- ☐ Wear my own clothes
- ☐ OK to have training medical staff observe labour & birth
- ☐ Other: _____

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
- ☐ Bath
- ☐ Fit ball
- ☐ Hot towels
- ☐ Hypnotherapy
- ☐ Other: _____

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

- [ ] Walking
- [ ] Squatting
- [ ] Kneeling
- [ ] Birth Stool
- [ ] Standing
- [ ] Sitting
- [ ] Lying down
- [ ] 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

- [ ] I would like to try to manage without medical pain relief options
- [ ] Gas / Air
- [ ] Epidural
- [ ] Pethidine
- [ ] 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
- [ ] Other support present
- [ ] Screen lowered at delivery
- [ ] I would like the procedure described as it is happening
- [ ] Other: _____

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: _____