BIRTH PREFERENCES WORKSHEET

Name _____ DOB _____

Healthcare Provider _____ EDD _____

Labor Support Team _____

I WOULD LIKE TO:

- ☐ KEEP THE NUMBER OF PEOPLE IN MY ROOM TO A MINIMUM
- ☐ HAVE THE LIGHTS DIMMED
- ☐ BRING FLAMELESS CANDLES
- ☐ LISTEN TO MY OWN MUSIC
- ☐ USE AROMATHERAPY
- ☐ BRING A "FOCAL POINT" FROM HOME
- ☐ _____

MONITORING:

- ☐ I PREFER INTERMITTENT MONITORING, AS LONG AS IT IS MEDICALLY APPROPRIATE TO DO SO
- ☐ IF CONTINUOUS MONITORING IS NECESSARY, I PREFER A PORTABLE MONITOR IF AVAILABLE
- ☐ _____

CERVICAL EXAMS:

- ☐ I PREFER AS FEW CERVICAL EXAMS AS POSSIBLE, AND ONLY WHEN MEDICALLY NECESSARY
- ☐ I DO NOT MIND CERVICAL EXAMS

MOBILITY:

- ☐ I PREFER FULL MOBILITY, INCLUDING WALKING AND CHANGING POSITIONS
- ☐ MOBILITY DURING LABOR IS NOT PARTICULARLY IMPORTANT TO ME

FLUIDS & FOOD:

- ☐ I WOULD LIKE TO AVOID IV FLUIDS UNLESS MEDICALLY NECESSARY, HOWEVER, I AM OPEN TO RECEIVING A HEPARIN LOCK
- ☐ I PREFER TO RECEIVE IV FLUIDS
- ☐ I WOULD LIKE TO EAT AND DRINK DURING LABOR IF IT IS SAFE FOR ME TO DO SO

PAIN MANAGEMENT:

- ☐ I WOULD LIKE TO USE NON-MEDICAL FORMS OF PAIN RELIEF
- ☐ I PREFER THAT PAIN MEDICATION ONLY BE OFFERED TO ME AT MY REQUEST
- ☐ I AM PLANNING TO RECEIVE PAIN MEDICATION AND I AM OPEN TO THE FOLLOWING METHODS:

_____

_____

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IF LABOR SLOWS:

- [ ] I WOULD LIKE TO TRY CHANGING LABOR POSITIONS, WALKING, AND OTHER NON-MEDICAL OPTIONS FIRST
- [ ] I PREFER THAT MY BAG OF WATERS BREAKS ON ITS OWN
- [ ] I PREFER THAT MY PROVIDER BREAKS MY BAG OF WATERS
- [ ] I PREFER TO HAVE PITOCIN ONLY IF MEDICALLY NECESSARY
- [ ] I WOULD LIKE TO LEARN MORE ABOUT THE RISKS AND BENEFITS OF PITOCIN
- [ ] _____

DELIEVERY PREFERENCES:

- [ ] I WOULD LIKE TO PUSH IN A POSITION OF MY CHOOSING
- [ ] I WOULD LIKE TO FOLLOW MY OWN BODY'S URGE TO PUSH RATHER THAN BEING DIRECTED TO PUSH
- [ ] I WOULD LIKE TO USE A MIRROR TO VIEW THE BIRTH OF MY BABY
- [ ] IF POSSIBLE, I PREFER DELAYED UMBILICAL CORD CLAMPING/CUTTING UNTIL THE CORD STOPS PULSATING
- [ ] I PLAN TO BANK THE CORD BLOOD WITH _____
- [ ] I PLAN TO TAKE MY PLACENTA HOME WITH ME

NEWBORN CARE PREFERENCES:

- [ ] IF MY BABY NEEDS TO LEAVE MY SIDE , I WOULD LIKE_____ TO REMAIN WITH HIM/HER/THEM
- [ ] PLEASE EXPLAIN ALL NEWBORN PROCEDURES AND MEDICATIONS BEFORE THEY ARE ADMINISTERED
- [ ] I PREFER TO: (CIRCLE WHAT APPLIES) DELAY/DECLINE ERYTHROMYCIN DELAY/DECLINE VITAMIN K DELAY/DECLINE HEP. B
- [ ] I PLAN TO EXCLUSIVELY BREASTFEED AND WOULD LIKE TO MEET WITH A LACTATION CONSULTANT
- [ ] UNLESS MEDICALLY NECESSARY, PLEASE DO NOT OFFER MY BABY ANY SUPPLEMENTATION
- [ ] I PREFER TO DELAY THE FIRST BATH
- [ ] I PLAN TO HAVE MY BABY CIRCUMCISED

IF A CESAREAN SECTION IS NECESSARY:

- [ ] I WOULD LIKE MY PARTNER TO STAY WITH ME AS MUCH AS POSSIBLE
- [ ] I WOULD LIKE THE SCREEN TO BE LOWERED SO I THAT I CAN VIEW THE BIRTH OF MY BABY
- [ ] I PREFER TO HAVE AT LEAST ONE ARM FREE TO TOUCH AND/OR HOLD MY BABY IF IT IS SAFE TO DO SO
- [ ] I WOULD LIKE MY BABY TO HAVE SKIN-TO-SKIN CONTACT WITH ME AND/OR MY PARTNER IN THE OPERATING ROOM
- [ ] I WOULD LIKE TO HOLD MY BABY SKIN-TO-SKIN DURING RECOVERY
- [ ] I WOULD LIKE TO BREASTFFED AS SOON AS POSSIBLE IN RECOVERY