POSTPARTUM CARE PREFERENCES

Name _____ DOB _____

Healthcare Provider _____

Infant's Name _____ DOB _____

Pediatrician _____

Emergency Contact #1:_____

Emergency Contact #2:_____

I WOULD LIKE THE BABY TO SLEEP:

- ☐ IN OUR ROOM, IN A BASSINET
- ☐ IN OUR ROOM, IN OUR BED
- ☐ IN THE NURSERY/OTHER ROOM

I PLAN TO FEED THE BABY:

- ☐ BY BREAST/CHEST, ON DEMAND
- ☐ BY BREAST/CHEST, SCHEDULED
- ☐ BY BOTTLE WITH PUMPED MILK
- ☐ BY BOTTLE WITH FORMULA

I PLAN TO HAVE:

- ☐ PREPARED MEALS DELIVERED
- ☐ FAMILY & FRIENDS BRING MEALS
- ☐ PRE-MADE MY OWN MEALS
- ☐ GROCERIES DELIVERED
- ☐ _____

MY SUPPORT NETWORK INCLUDES:

- ☐ MY PARTNER/SPOUSE
- ☐ FAMILY _____
- ☐ FRIENDS _____
- ☐ MY DOULA _____
- ☐ _____

I WOULD LIKE VISITORS TO COME:

- ☐ AS SOON AS POSSIBLE
- ☐ WITHIN THE FIRST 2-3 WEEKS
- ☐ ONLY IF/WHEN INVITED

WE WILL NEED SUPPORT FOR:

- ☐ OUR OLDER CHILD(REN)
- ☐ OUR PET(S)
- ☐ _____
- ☐ _____
- ☐ _____

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TO FEEL SUPPORTED I NEED:

- [ ] ______________________________
- [ ] ______________________________
- [ ] ______________________________
- [ ] ______________________________
- [ ] ______________________________

THREE DAILY GOALS I HAVE ARE:

- [ ] ______________________________
- [ ] ______________________________
- [ ] ______________________________

TO FEEL CONNECTED AS A COUPLE WE NEED:

- [ ] ______________________________
- [ ] ______________________________
- [ ] ______________________________
- [ ] ______________________________
- [ ] ______________________________

WE ABSOLUTELY DO NOT WANT:

- [ ] ______________________________
- [ ] ______________________________
- [ ] ______________________________
- [ ] ______________________________
- [ ] ______________________________