

(Your last name here)

# Family Birth Preferences

Estimated Due Date \_\_\_\_\_

Mother's Name \_\_\_\_\_

Partner's Name \_\_\_\_\_

Midwife/OB \_\_\_\_\_

Doula/Assistant Coach \_\_\_\_\_

We are very excited about the upcoming birth of our son/daughter/child. We are hoping for an uncomplicated and safe delivery. We would like an informed birth experience and would appreciate your help and guidance. We have the utmost confidence in our chosen birth team. We also believe that birth is a normal and natural process and are hoping to avoid medical interventions and drugs. Please help us in any way you can to achieve these goals.

THINGS WE WOULD LIKE:	THINGS WE WOULD LIKE TO AVOID:
<input type="checkbox"/> A healthy mom and healthy baby <input type="checkbox"/> An informed birth experience <input type="checkbox"/> Coach present at all times <input type="checkbox"/> A natural, vaginal birth <input type="checkbox"/> Limited vaginal exams <input type="checkbox"/> Intermittent fetal monitoring <input type="checkbox"/> Freedom of movement during labor <input type="checkbox"/> A peaceful, quiet environment <input type="checkbox"/> Access to a tub or shower <input type="checkbox"/> Limited interruptions <input type="checkbox"/> Freedom to choose birth position <input type="checkbox"/> Freedom to eat and drink during labor <input type="checkbox"/> Immediate skin-to-skin contact with our baby <input type="checkbox"/> Delay cord clamping until pulsing has stopped <input type="checkbox"/> Coach to cut cord <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Cesarean Surgery <input type="checkbox"/> Medication <input type="checkbox"/> Induction <input type="checkbox"/> Artificial rupture of membranes <input type="checkbox"/> Time limits on first and second stage labor <input type="checkbox"/> I.V. <input type="checkbox"/> Continuous monitoring <input type="checkbox"/> Instrumental delivery <input type="checkbox"/> Routine pitocin after birth <input type="checkbox"/> Directed pushing <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

# Baby Care Plan

THINGS WE WOULD LIKE:	THINGS WE WOULD LIKE TO AVOID:
<input type="checkbox"/> Immediate skin-to-skin contact with our baby <input type="checkbox"/> NO SEPARATION OF MOTHER & BABY <input type="checkbox"/> Exclusive breastfeeding <input type="checkbox"/> Delayed newborn procedures <input type="checkbox"/> APGAR and other assessments performed while on mom's chest <input type="checkbox"/> Delayed bath <input type="checkbox"/> Consultation with Lactation Consultant <input type="checkbox"/> 24/7 Rooming in <input type="checkbox"/> All assessments done in parents' room <input type="checkbox"/> To go home as soon as possible <input type="checkbox"/> _____	<input type="checkbox"/> Baby in the nursery <input type="checkbox"/> Hep-B vaccine <input type="checkbox"/> Circumcision <input type="checkbox"/> Bottles, pacifiers, artificial nipples/feeding <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____