Birth Plan

NAME: ____ **PRONOUNS:** ____ **AGE:** ____

RACE/ETHNICITY: ____ **DUE DATE:** ____

DOCTOR/MIDWIFE: ____ **BABYNAME:** ____

LOCATION: ____

SETTING: ☐ hospital ☐ birth center ☐ home **I ALSO NEED:** ☐ transportation ☐ translator

BIRTH TYPE: ☐ vaginal ☐ cesarean ☐ VBAC ☐ water **INDUCTION DATE:** ____

HEALTH FACTORS: ____

ALLERGIES: ____

Birth Team

Name:	Relationship:	Role:

Medical Interventions/Induction

In case of C-section, I would like:

☐ one free arm ☐ clear drapes ☐ to stay awake

I consent to the following procedures:

- ☐ Cervical checks
- ☐ Epidural
- ☐ Episiotomy
- ☐ Pitocin
- ☐ Electronic fetal monitoring (continued or intermittent)
- ☐ Membrane sweep
- ☐ Cervix ripening agents (pill, gel, or vaginal insert)
- ☐ Amniotomy (intentional breaking of water)
- ☐ Cervix balloon
- ☐ IV Connection

Pain Management

If medically possible, I would prefer:

- ☐ Breathing/Meditation
- ☐ Massage
- ☐ Nitrous Oxide
- ☐ Visualization
- ☐ Hydrotherapy
- ☐ IV Medication
- ☐ Epidural
- ☐ Vocalization (low moaning or grunts)
- ☐ Changing Positions:
  - ☐ lying on back
  - ☐ lying on side
  - ☐ squatting
  - ☐ standing
  - ☐ on all fours

Comfort Measures

- ☐ music played (I will provide)
- ☐ the lights dimmed
- ☐ the room as quiet as possible
- ☐ as few interruptions as possible
- ☐ birth affirmations
- ☐ aromatherapy
- ☐ to walk/ movement
- ☐ to film and/or take pictures
- ☐ birthing/ Peanut Ball
- ☐ to stay hydrated with clear liquids and ice chips
- ☐ to eat and drink as approved by my doctor
- ☐ only my own doctor and nurses in the room (no students, residents or interns)

Newborn Procedures

- ☐ All procedures and medications are to be explained to me beforehand.
- ☐ I want my baby to be circumcised.
- ☐ Golden hour (1 hour of uninterrupted skin to skin contact).
- ☐ Newborn vaccines (vitamin K shot, eye - ointment).
- ☐ Infant Feeding: BF/ formula/ Donated Human milk
- ☐ If my baby has to be taken from me for medical treatment, I want my support person to go with them.
- ☐ I want to keep my placenta for encapsulation or artwork. (A cooler must be provided by the family.
- ☐ Cord Care: Cut/Delayed cord clamping. Who will cut umbilical cord: ______________________

Additional Notes

Photo Consent

This is completely optional and entirely customizable, and will not be done without clear consent. With your consent, doula and back -up doula will take photos, audio and video recordings using a cell phone or digital camera to document your pregnancy, labor and birth experience at no extra cost. All documentation will be sent to the client's email on file in the form of a restricted google drive folder. This folder will be continuously updated throughout your experience. Any photos or videos containing nipples, genitalia, or the faces of minor children will be deleted from all of the Doulas' recording devices promptly after each time the folder is updated. Any consent given can be modified or revoked at any time.

Please circle (1) informed decision for your birth experience:

- **I fully consent** to my doula and back-up doula taking photos, audio, and video recordings of my pregnancy, labor and birth experience.
- **I do not consent** to my doula and back-up doula taking photos, audio, and video recordings of my pregnancy, labor and birth experience.
- **I partially consent** to my doula and back-up doula taking photos, audio, and video recordings of my pregnancy, labor and birth experience under the following conditions:

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Client signature & Date: ____________________________

Doula Signature & Date: ____________________________