

## **TO MY HEALTHCARE PROVIDER(S)**

This birth plan outlines my preferences and requests for my labor and delivery. I understand that unforeseen circumstances may necessitate deviations from this plan, and I am open to discussing alternatives with you. However, this document serves as formal notice of my wishes and priorities, and I request that you give them serious consideration. I appreciate your collaboration in making my birth experience as safe, positive, and aligned with my preferences as possible.

# THE JOYFUL BIRTH PLAN

## SECTION 1

### About Me & My Preferences

Mother's Name:

Due Date:

Partner's Name (if applicable):

Phone Number:

Email Address:

Doctors Name:

Birth Support (and relationship):

## SECTION 2

### Labor & Delivery Preferences

#### CLOTHING PREFERENCE

Hospital Gown

My Own Clothes

#### FETAL MONITORING

Check all that apply; explain preferences if needed.

Continuous External Monitoring (Belly Band)

Bluetooth Fetal Monitoring (If available)

Intermittent External Monitoring (Doppler)

Internal Fetal Monitoring (Internal Electrode)

#### IV/SALINE LOCK

IV Access

No IV/Saline Lock (If selecting this, please explain your rationale)

Saline Lock Only

## EATING AND DRINKING DURING LABOR

Specify preferences.

Yes

No

---

## LABOR ENVIRONMENT

Check all that apply; describe your ideal environment.

Lighting

Specific Sounds/Music

Aromatherapy

Comfort Items (e.g., blanket, pillow)

Other Environmental Preferences

---

## COUNTER PRESSURE

Describe your preference for counter-pressure application, if desired. Specify location, pressure level, and whether you want continuous or intermittent pressure.

Ex.: "Yes, firm counter pressure on my lower back during contractions."

Yes

No

## PHYSICAL TOUCH

Specify your preference for other types of physical touch, such as head massage, back rubs, holding hands, etc.

Yes

No

---

## PAIN MANAGEMENT

Rank in order of preference.

None     Epidural     Nitrous Oxide (not standard)

Other (Specify)

---

## INDUCTION INTERVENTIONS (If medically necessary)

Rank in order of preference, or "Not Applicable".

Membrane Sweep     Amniotomy (Artificial Rupture of Membranes)     Cytotec     Pitocin

Other (Specify)     Balloon Foley

---

## BIRTHING INTERVENTIONS (If medically necessary)

Rank in order of preference, or "Not Applicable".

Forceps     Vacuum Extraction     Episiotomy

Other (Specify)

---

## MOVEMENT DURING LABOR

Free movement (walk, change positions as needed)     Primarily in bed

Exercise ball     Peanut ball

### CERVICAL CHECKS

Specify your preference.

- Yes, only when asked for.
  - Yes (Frequency: \_\_\_\_\_ )
  - Yes, but don't want to know the dilation.
  - No
- 

### PUSHING

- Mother-Led Pushing (intuitive pushing)
  - Coached Pushing (guided by healthcare provider or birth coach)
- 

### MIRROR DURING DELIVERY

- Yes
  - No
- 

### PHOTOGRAPHY/VIDEOGRAPHY

- Photos Only
  - Video Only
  - Both Photos and Video
  - Neither
- 

**SAFE WORD** (For indicating a need to switch to medicated birth if coping becomes difficult)

**ANY BIRTH WORD PREFERENCE** (Ex. Contractions being called surges or waves)

### SECTION 3

#### Post-Delivery Preferences

##### IMMEDIATE SKIN-TO-SKIN

Yes  No

##### DELAYED CORD CLAMPING

Yes  No

- After specified time
- Until placenta is completely drained and cord is limp and white

##### CUTTING THE CORD

Partner  Myself  Other (Specify)

##### PLACENTA DELIVERY

Spontaneous (natural delivery)  Dr. Assisted  Pitocin-assisted (if medically indicated)

##### PLACENTA RETENTION

Discard Placenta  Keep Placenta

##### POSTPARTUM PITOCIN

Yes  No (If selecting no, please explain rationale)

**GOLDEN HOUR** (Undisturbed bonding time immediately following birth)

---

**FEEDING METHOD**

Breastfeeding

Bottle Feeding (specify type of formula, if applicable)

Both

**SECTION 4**

Newborn Care Preferences

**ANTIBACTERIAL EYE OINTMENT**

Yes  No

---

**HEPATITIS B VACCINE**

Yes  No

---

**VITAMIN K SHOT**

Yes  No

---

**VERNIX CLEANING**

Leave  Wipe off

---

**CIRCUMCISION**

Yes  No

In hospital

At doctor's office

## NEWBORN CARE LOCATION

Rooming-in (baby stays with mother)  Nursery (baby stays in nursery)  Both- at my request

---

## BABY FOOTPRINTS

Yes  No

## SECTION 5

Other Information

## ANY OTHER IMPORTANT PREFERENCES OR CONSIDERATIONS

Disclaimer: This birth plan is a guide to assist communication with your healthcare provider. Medical needs may necessitate changes to the plan. It's essential to discuss all aspects of this plan with your healthcare provider and agree on a feasible course of action based on your individual circumstances.

