My Birth Preferences

Mom's Name: _____ Date of Birth: _____

OB/GYN: _____ Due Date: _____

Baby's Sex/Name : _____ Baby Number_____

Pediatrician: _____How You Heard About Us_____

Please note that I have:

- Group B strep
- Rh incompatibility with baby
- Gestational diabetes
- Hypertension
- Other:_____
  _____

My delivery is planned as:

- Vaginal
- C-section
- Trial of labor after Cesarean (TOLAC)
- Adoption Delivery
- Surrogacy Delivery

Bolded items must be discussed with physician at next available appointment*

During Labor/Delivery

My primary support person is:

Name: _____ Relationship: _____

Phone Number: _____

Other people I want with me in labor are: ***(Limit of 4)***

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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This form is **NOT** a part of the Permanent Medical Record

Name:_____
DOB: _____

During labor, I'd like:

- Music played
- Lights dimmed
- Aromatherapy
- Room as quiet as possible
- As few interruptions as possible
- **As few vaginal exams as possible**
- **To let my water break naturally**
- **Wireless monitoring**
- **Intermittent monitoring**
- To wear my own clothes
- My partner to be present the entire time
- To use props, such as:
    - Birthing ball
    - Peanut ball
    - Chair/stool
    - Birthing bar
    - Massage Tool
    - Other: _____

During labor, I would like the following support:

- Help with breathing
- Help working through contractions
- Use of positioning techniques
- Hypnobirthing childbirth class
- Massage
- Doula: Arrangements to be made by myself
- Other: _____

If Labor Augmentation is needed, I would like it to be:

- **Performed with medication (ex. Pitocin)**
- **Artificial Rupture of Membranes**

Name:_____
DOB: _____

During labor I'd like:

- **To Walk around**
- **To Stand up**
- **To shower**
- **Labor in a tub, if available**
- To be in a labor bed

I would like to try the following positions, in addition to lying in bed:

- Semi-reclining
- Side-lying position
- Squatting
- Hands and knees
- **Freedom /Ability to change positions as to whatever feels right**

What kind of pain management assistance, if any, do I want during labor?

- **I plan to labor without the use of pain medication.**
- I will ask for pain medication if I need it. Please **DO NOT** medications to me
- *Before receiving pain medication, my goal is to let my pain reach level ____(on a scale 0/10)*
- I would like to be offered pain medication.
- **Epidural**
- **IV Pain Medication**

During Delivery

As the baby is delivered, I would like to:

- **Push spontaneously with contractions**
- Push as directed
- **Push without time limits per ACOG standards, as long as the baby and I are not at risk**
- Use a mirror to see the baby crown
- Let the epidural wear off while pushing
- Have a full dose of epidural
- Use whatever methods my doctor deems necessary
- **My support person or I to touch my baby at the moment of birth**
- **Episiotomy, if needed**
- **Tear naturally**

Name:_____
DOB: _____

My support person would like to help:

- Coach me through pushing
- Cut the umbilical cord
- Assist in obtaining first weight and measurements

Immediately after delivery, I would like:

- To see the placenta before it is discarded
- To save my placenta
- **To delay clamping and cutting the umbilical cord**
- To save my baby's umbilical cord blood so I may bank or donate it *(Moms must request and obtain a kit from your cord-blood bank of choice. Your medical team will help to collect the cord blood. Patients are then responsible for sending the blood off to the cord-blood bank.)*

If C-section is necessary, I would like:

- To stay conscious by using Spinal/epidural for anesthesia if possible *(this can be discussed with your anesthesiologist or nurse anesthetist on delivery day)*
- My support person to remain with me the entire time *(in the event general anesthesia is needed, your support person will be asked to leave the room)*
- **The ability to have dialog with my physician during surgery**
- **The screen lowered so I see my baby right after delivery before handing off to nurse.**
- To hold my baby skin-to-skin in the operating room, if possible.
- My support person to hold the baby as soon as possible.
- To breastfeed in the recovery room if possible.

After Delivery (Vaginal or Cesarean)

As a designated Baby-Friendly facility, Sacred Heart recommends allowing your baby to stay skin-to-skin with you uninterrupted for at least 1-2 hours after birth. Compared with babies who are swaddled or kept in a crib, skin-to-skin babies stay warmer, cry less and maintain more stable vital signs, such as heart rate, respiratory rate, blood sugar and blood pressure.

At Sacred Heart we practice Couplet Care or also known as rooming in. This means you and your baby share a room on the Post-Partum unit.

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Name:_____
DOB: _____

I, or my support person, would like to hold my baby skin-to-skin:

- Immediately after delivery
- After baby is wiped clean

I would like to breastfeed:

- As soon as possible after delivery
- Before eye drops/ointment are given
- I prefer not to breastfeed

I would like the following people: _____

- To join me and baby immediately after delivery
- To join me and baby once we have moved to our postpartum Mother-Baby room
- Other:_____

I would like baby's medical exams and procedures:

- Given only after we've had time to bond
- Given in my or my support person's presence

I understand that routine newborn care includes: antibiotic eye treatment*, Vitamin K administration*, Metabolic Screening Test*, Hepatitis B Vaccine administration*, Hearing screening* and Congenital Heart Disease testing.

- I understand.
- I plan to Delay_____
- I plan to decline _____

Mother will be required to sign a declination form to delay or refuse any starred (*) item.

I would like to feed baby:

- Only Breast milk
- With the help of a lactation specialist
- Breast and Bottle
- Only formula
    - Brand preference: _____

Maternity & Women's
SACRED HEART HOSPITAL PENSACOLA

Name:_____
DOB: _____

I would like baby's first bath given:

- In my or my support person's presence
- By me or my support person
- Other: _____

If we have a boy, a circumcision should:

- Not be performed
- Be performed
- **In the presence of me and/or my partner if possible**
- **Be performed later in my physician's office**

If baby is not well, I'd like:

- My support person to accompany my baby to the Neonatal Intensive Care Unit (NICU) or Newborn Nursery (NBN)
- My support person and I to visit the baby once stabilized in the NICU/NBN
- My support person and I to accompany baby when any testing is done, if possible
- To breastfeed or provide pumped breastmilk
- To hold baby whenever possible

As needed post-delivery, please give me:

- Medication upon request as ordered by my physician
- Warm blankets
- Ice packs

These are special traditions I want to take place when my baby is born: _____

_____

_____

Please describe any other issues the hospital staff should know about me or my baby's birth:

_____

_____

_____

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Name:_____
DOB: _____

Partnering with Your OB/GYN

The health and safety of both you and your baby are of the utmost importance, which is why – after working with your birth designer to develop your customized birth preferences – we ask you to take this document to your next doctor's appointment and review it with your OB/GYN.

This collaboration between you, your hospital birth designer and your OB/GYN ensures that your vision for delivery aligns with your physician's recommendations for the care you and your baby need.

Your birth preferences will be kept on file at the hospital so your care team can access your information upon your arrival at the hospital for the birth of your baby. You should keep a copy of your birth preferences and bring this with you when you come to the hospital to deliver.

We strive to accommodate your requests to the best of our ability. However, please know that the health and safety of mother and baby are always the priority and that, depending on the circumstances, your physician and care team may need to deviate from your preferences in order to keep you and/ or your baby safe. Please understand nothing in this care preferences list is legally binding, nor is it intended to replace the process of informed consent.

Patient Signature:_____ Date: _____

Birth Designer Signature:_____ Date: _____