

Birth Plan



General Information

Name + Pronouns: _____

Due Date: _____

Partner Info: _____

Provider Name + Info: _____

Medical Need -To-Knows

- | | |
|---|--|
| ☐ Allergies: _____ | ☐ Prior c-section |
| ☐ Fear of needles | ☐ Rh incompatible with baby |
| ☐ Gestational diabetes | ☐ STI |
| ☐ Group B strep positive | ☐ Other: _____ |
| ☐ Preemclampsia | |

Type of Delivery

- ☐ Vaginal
- ☐ VBAC
- ☐ C-section
- ☐ Water birth

Labor & Delivery Team

- ☐ Partner
- ☐ Parent
- ☐ Older children
- ☐ Doula
- ☐ Other: _____

Labor Preferences

- | | |
|--|---|
| ☐ Partner/support person present throughout | ☐ Visitors allowed |
| ☐ Aromatherapy | ☐ Photography allowed |
| ☐ Dim lights | ☐ No residents/interns |
| ☐ Music | |

Pain Management

- | | |
|---|---|
| ☐ Epidural | ☐ Meditation |
| ☐ Nitrous oxide | ☐ Massage |
| ☐ Deep breathing exercises | ☐ Shower/bath |
| ☐ TENS Unit | ☐ Stretches |
| ☐ Birthing ball | ☐ Do not offer pain medication |
| ☐ Other _____ | |

If a Boy, Circumcision Preferences

- ☐ Occur in the hospital
- ☐ Be performed with local anesthesia
- ☐ Be done in the presence of myself and/or my support person
- ☐ Occur outside the hospital
- ☐ Not be performed

Breastfeeding Preferences

- ☐ Only breastmilk
- ☐ Pumped breastmilk
- ☐ Donor milk, if needed
- ☐ Infant formula
- ☐ Infant formula, only if necessary
- ☐ Combo of breastmilk and formula

- ☐ Would you like to see a lactation consultant?



UNITED WAY
Southwest Virginia

