Arise Birth & Wellness: Birth Plan

CONTACT INFORMATION

Birthing Person's Full Name

Birthing Person's Gender Identity

Birthing Person's Pronouns

Birthing Person's Phone Number

Partner Full Name

Partner's Gender Identity

Partner's Pronouns

Partner's Phone Number

Birthing Person's Designated Medical Power of Attorney

Please select one

○ Partner ○ Other

Other: Name, Relationship, Phone Number

Other Genetic Contributor to Baby (Father of the Baby): Name, Relationship, Phone Number

Baby's Name-To-Be

Estimated Due Date

Primary Provider

Primary Birth Provider Type

Please select one

CPM CNM OB/GYN MFM Family Medicine Free/Sovereign Birth ARNP Other

Other:

Provider's Phone Number

Baby's Provider

Provider Type

Please select one

○ Pediatrician ○ Neonatologist ○ Perinatologist ○ Family Medicine ○ ARNP ○ Other

Other:

Baby's Provider Phone Number

Doula

Doula's Phone Number

Birth Photographer:

Birth Photographer's Phone Number:

Cord Blood Bank

Cord Blood Bank's Phone Number

Other Service Providers: Name, Type, Phone Number

Other Support Individuals: Name, Relationship, Phone Number

BIRTHING PERSON HEALTH INFORMATION

Medication Allergies

Current Medications: Name, Dosage, and Frequency

Group B Strep

Please select one

○ Positive ○ Negative ○ Will Test Later ○ Will Not Test ○ Considering Test

If Positive, Antibiotic Preferences:

Please select one

○ Antibiotics ○ Will Not Accept Antibiotics ○ Considering Antibiotics

Herpes

Please select one

○ Positive ○ Negative ○ Will Test Later ○ Will Not Test ○ Considering Test

Herpes Active Lesions

Please select one

○ Present ○ Not Present

Hepatitis B

Please select one

○ Postive ○ Negative ○ Will Test Later ○ Will Not Test ○ Considering Testing

Chlamydia

Please select all that apply

☐ Negative
☐ Positive, Untreated
☐ Previously Positive During Pregnancy, Treated to Cure, Partner Untreated
☐ Previously Positive During Pregnancy, Treated to Cure, Partner Treated to Cure
☐ Unknown
☐ Will Test Later
☐ Will Not Test
☐ Considering Testing

Comments:

Vaccination Status

Please select one

○ Up to Date ○ Not Up to Date

Comments:

Birthing Person's Blood Type

Genetic Contributor's Blood Type, If Known

Baby's Blood Type, If Known

Rh Compatibility

Please select one

- ○ Compatible
- ○ Incompatible
- ○ Unknown
- ○ Will Not Test
- ○ Considering Test

Blood Products

Please select one

- ○ Will Accept
- ○ Will Not Accept
- ○ Considering Accepting

Glucose Tolerance Testing

Please select one

- ○ Already Tested with Standard Test
- ○ Will Test with Standard Test
- ○ Considering Standard Test
- ○ Will Test with Alternative Test
- ○ Tested with Alternative Test
- ○ Will Not Test

Birthing Person's History

Please select all that apply

- ☐ Chronic Hypertension
- ☐ Gestational Hypertension
- ☐ Pre-Eclampsia
- ☐ Eclampsia
- ☐ Metabolic Syndrome/Pre-Diabetes
- ☐ Diabetes, Type 1
- ☐ Diabetes, Type 2
- ☐ Gestational Diabetes
- ☐ Rh Incompatibility
- ☐ Headaches/Migraines
- ☐ Seizures
- ☐ Sexual Abuse/Assault
- ☐ Depression
- ☐ Bipolar Disorder

History Information

Birthing Person's Conditions

Please select all that apply

- [ ] Gestational Diabetes
- [ ] Chronic Hypertension
- [ ] Gestational Hypertension
- [ ] Pre-Eclampsia

Current Condition Information

LABOR PREFERENCES

Preferred Delivery Method

Please select one

- ○ Spontaneous Vaginal Delivery
- ○ Induced Vaginal Delivery
- ○ Planned Cesarean Section

Preferred Delivery Method

Please select all that apply

- [ ] Spontaneous Vaginal Delivery
- [ ] Induced Vaginal Delivery
- [ ] Planned Cesarean Section
- [ ] Vaginal Birth After Cesarean (VBAC)
- [ ] Vaginal Birth After Two Cesareans (VBA2C)
- [ ] Vaginal Birth After (More) Cesareans
- [ ] Water Birth
- [ ] Lotus Birth

Preferred Delivery Location

Please select one

○ Home ○ Birth Center ○ Hospital ○ Other

Birth Center/Hospital: Name, City, Phone Number

Other: Location, City, Phone Number

Emergency Phone Number

Alternative/Emergency Transfer Destination: Name, City, Phone Number

When to Contact Provider

When to Travel to Delivery Location

When to Contact Doula

When to Contact Birth Photographer

When to Contact All Other Providers

Preferred Companions in Delivery Room

Preferred Companion in Operating Room

In the Delivery Room, the Birthing Person Wants:

Please select all that apply

- [ ] Dim Lighting
- [ ] Minimal Sound
- [ ] Birth Ball
- [ ] Peanut Ball
- [ ] Few Interruptions (Cluster Care)
- [ ] No Students
- [ ] Wear Own Clothes
- [ ] Wear Glasses/Contact Lenses
- [ ] Support Person Always Present
- [ ] Photography
- [ ] Videography
- [ ] Ability to Eat/Drink at Will

Music Playlist

Essential Oils

Items from Home

Special Lighting (Projections, Fairy Lights, etc.)

For a Vaginal Birth, the Birthing Person Would Like to:

Please select all that apply

- ☐ View the Birth Using a Mirror
- ☐ Touch the Baby's Head as it Crowns
- ☐ Be Helped with Position Changes
- ☐ Feel the Urge to Push Prior to Pushing
- ☐ Not Push While Supine
- ☐ Labor at Home as Long as Possible
- ☐ Catch the Baby

Comments:

Preferred Labor Discomfort Management Techniques

Please select all that apply

- ☐ Birth Tub
- ☐ Bathtub
- ☐ Shower
- ☐ Massage
- ☐ Acupressure
- ☐ Acupuncture
- ☐ Breathing Techniques
- ☐ Hypnobirthing
- ☐ Sterile Water Injections
- ☐ TENS
- ☐ Heat/Cold Application
- ☐ Meditation
- ☐ Reflexology
- ☐ Reiki
- ☐ Medications
- ☐ Nitrous Oxide
- ☐ Standard Epidural
- ☐ Walking Epidural
- ☐ Would Like Epidural Turned Down During Pushing
- ☐ Do Not Offer Pain Relief
- ☐ Do Not Offer Medications
- ☐ Do Not Offer Anesthesia/Epidural

Comments:

LABOR INDUCTION OR AUGMENTATION

Preferred Methods of Cervical Preparation

Please select all that apply

- ☐ Cervidil/Dinoprostone Vaginal Insert (FDA Approved)
- ☐ Cervidil/Dinoprostone Cervical Gel (FDA Approved)
- ☐ Cytotec/Misoprostol (Off-Label Use)
- ☐ Foley Catheter, Single Balloon (Off-Label Use)
- ☐ Foley Catheter, Double Balloon (FDA Approved)
- ☐ Cook Catheter, Single Balloon (Off-Label Use)
- ☐ Cook Catheter, Double Balloon (FDA Approved)
- ☐ Other Catheter

Comments:

Preferred Methods of Induction

Please select all that apply

- ☐ Membrane Sweep
- ☐ Artificial Rupture of Membranes (AROM)
- ☐ Cytotec/Misoprostol
- ☐ Oxytocin/Pitocin
- ☐ Walking
- ☐ Nipple Stimulation
- ☐ Sexual Activity
- ☐ Midwives' Brew
- ☐ Herbs
- ☐ Castor Oil
- ☐ Acupressure
- ☐ Acupuncture

Comments:

ADDITIONAL BIRTH INFORMATION

Non-Routine Techniques to be Used Only When Medically Necessary and After the Birthing Person's Informed Consent

Please select all that apply

- ☐ Vacuum
- ☐ Forceps
- ☐ Episiotomy
- ☐ Cesarean Section
- ☐ Fetal Scalp Electrode
- ☐ Intrauterine Pressure Catheter
- ☐ Artificial Rupture of Membranes (AROM)

Comments:

Vaginal Exams

Please select all that apply

- ☐ On Admission
- ☐ Routine (Q4)
- ☐ Whenever Needed
- ☐ As Few as Possible

Comments:

IV Preferences

Please select all that apply

- ☐ No Routine IV Access
- ☐ Heparin Lock/Saline Lock
- ☐ Routine IV Fluids

Comments:

Monitoring Preferences

Please select all that apply

- ☐ Continuous Fetal Monitoring
- ☐ Intermittent Fetal Monitoring
- ☐ Wireless Fetal Monitoring
- ☐ Intermittent Auscultation
- ☐ Fetoscope/Pinard Horn

Comments:

Cesarean Section Preferences

Please select all that apply

- ☐ A Moment Alone with Support Individuals Prior to Procedure
- ☐ Support Person Present During Procedure
- ☐ Sheer Screen/Lowered Screen
- ☐ No Arm Restraints
- ☐ On-Going Explanations of Procedure
- ☐ Music
- ☐ Immediate Skin-to-Skin with Birthing Person
- ☐ Immediate Skin-to-Skin with Support Person
- ☐ Second Opinion on C-Section Decision
- ☐ Epidural/Spinal Block (Avoid General Anesthesia)
- ☐ Breast/Chest/Bodyfeed in Recovery Room
- ☐ Gentle C-Section

Comments:

Perineum Preferences

Please select all that apply

- ☐ Hands-Off Care
- ☐ Perineal Massage
- ☐ Oil
- ☐ Tears Repaired with Local Anesthesia
- ☐ Tears Repaired with Epidural Still in Place

FIRST MOMENTS

Person to Catch the Baby

The Birthing Person Would Like to First Hold the Baby:

Please select all that apply

- ☐ Immediately, Skin-to-Skin
- ☐ Immediately, on a Blanket or Towel
- ☐ After Being Wiped Clean
- ☐ After Being Cleaned and Weighed

Comments:

Umbilical Cord & Placenta

Please select all that apply

- ☐ Delayed Cord Clamping/Cutting
- ☐ Clamping/Cutting After the Cessation of Pulsation
- ☐ Lotus Birth
- ☐ Birthing Person Will Take Placenta Home
- ☐ Birthing Person Will Take Home a Section of Cord
- ☐ Cord Blood Will Be Banked
- ☐ Wishes to Donate Cord Blood
- ☐ Placenta Will Be Banked
- ☐ Wishes to Donate Placenta
- ☐ No Preferences
- ☐ Birthing Person Would Like to See the Placenta Prior to It Being Discarded
- ☐ Birthing Person Would Like to Photograph the Placenta Prior to It Being Discarded

Person to Cut the Umbilical Cord

If Applicable, Birthing Person's Definition of Delayed Cord Clamping

BABY

Baby Medications/Procedures

Please select all that apply

- ☐ Vitamin K
- ☐ Erythromycin Eye Ointment
- ☐ Hepatitis B Vaccine
- ☐ Hearing Test
- ☐ PKU
- ☐ Heel-Stick Screening Tests

Intended Feeding Methods

Please select all that apply

- ☐ Breast/Chest/Bodyfeeding Alone
- ☐ Breast/Chest/Bodyfeeding with Human Milk Bottle Supplementation When Needed
- ☐ Breast/Chest/Bodyfeeding with Formula Bottle Supplementation When Needed

- [ ] Formula
- [ ] Donated Human Milk
- [ ] Sugar Water
- [ ] Pumping

Formula/Bottle Brands

Birthing Person Will Begin Breast/Chest/Bodyfeeding

Please select all that apply

- [ ] Immediately
- [ ] When Comfortable
- [ ] After Meeting with a Lactation Consultant
- [ ] Do Not Offer Breast/Chest/Bodyfeeding
- [ ] Someone Else Will Breast/Chest/Bodyfeed

Nipple Options

Please select all that apply

- [ ] No Other Nipples
- [ ] Pacifier Only
- [ ] Bottles, No Pacifier
- [ ] Bottles and Pacified

Comments:

Circumcision

Please select all that apply

- [ ] Baby Will Be Circumcised Prior to Leaving Hospital
- [ ] Baby Will Be Circumcised After Leaving Hospital
- [ ] Baby Will Be Circumcised By Non-Hospital Personnel
- [ ] Unsure
- [ ] In Presence of Birthing Person or Partner

Comments:

Circumcision Pain Relief

Please select all that apply

- ☐ Sugar Water
- ☐ Wine
- ☐ Anesthesia
- ☐ Pain Medications
- ☐ Breast/Chest/Bodyfeeding or Bottle

Comments:

Rooming In/Nursery

Please select all that apply

- ☐ Rooming In is Preferred
- ☐ Nursery is Preferred
- ☐ Both are Acceptable as Needed
- ☐ Day: Room; Night: Nursery

Comments:

Procedures

Please select all that apply

- ☐ All Baby Exams in Presence of Birthing Person/Support Person

- [ ] Medical Exams/Procedures Should Be Done After Bonding When Possible

Comments:

NICU Stay

Please select all that apply

- [ ] Birthing Person/Partner/Support Person Will Accompany Baby to NICU
- [ ] Human Milk Will Be Provided
- [ ] Donated Human Milk Will Be Provided
- [ ] Birthing Person/Partner/Support Person Would Like to Hold the Baby As Much As Possible

Comments:

BIRTHING PERSON HOSPITAL STAY

Length of Stay

Please select all that apply

- [ ] One Day
- [ ] Two Days
- [ ] Three Days
- [ ] As Long as Possible
- [ ] As Short as Possible

Comments:

Post-Birth Medications

Please select all that apply

- ☐ Tylenol/Acetominophen
- ☐ Opiates
- ☐ Stool Softeners
- ☐ Laxatives
- ☐ Enema

VALUES IN THE CONTEXT OF THIS BIRTH EXPERIENCE

What Does "Success" Look Like?

What is the Most Important Aspect of the Birthing Experience?

What Are You Most Looking Forward To?

What is Your Greatest Fear?

What is Your Most Unique Request?