

BIRTH PLAN

Our birth plan is intended to express preferences and desires for your birth experience, and our purpose is to assist you in delivering a healthy newborn. This plan may be altered due to changes in your condition or the condition of your baby. If changes occur, we will ALWAYS discuss options with you so that you are able to make informed decisions about the care you and your baby are receiving.

For information about Childbirth Preparation Classes or to register call 812-283-2405.

If you are interested in touring our Family Birth Place, please call 812-283-2050 to schedule a tour.

YOUR NAME

EMAIL

NAME OF YOUR MIDWIFE & OBSTETRICIAN

DUE DATE

ENVIRONMENT *(Check all that apply)*

- Dim lights Music TV Wear my own clothes Other (Please describe) _____

REQUESTS FOR LABOR

Physical ability to *(Check all that apply)*

- Be mobile Walk Rock Squat Try multiple positions Use tub/shower Use Birthing ball Use Peanut ball

Various Options *(Check all that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Heparin Lock only (no running IVs unless medically necessary) | <input type="checkbox"/> Continuous Monitoring with telemetry capabilities |
| <input type="checkbox"/> Intermittent Monitoring (ACOG Standards) | <input type="checkbox"/> Please do not offer me pain control options, I will ask if I need it |
| <input type="checkbox"/> Pain medication offered if I'm uncomfortable | <input type="checkbox"/> Please do not offer me an epidural |
| <input type="checkbox"/> Epidural as soon as possible | <input type="checkbox"/> Directed Pushing <input type="checkbox"/> Offer pushing position options |
| <input type="checkbox"/> Spontaneous Bearing Down | <input type="checkbox"/> Prefer to tear instead of having an episiotomy |
| <input type="checkbox"/> Prefer no episiotomy | <input type="checkbox"/> Pitocin |
| <input type="checkbox"/> To begin labor on my own | <input type="checkbox"/> Rice sock for comfort (bring your own) |
| <input type="checkbox"/> Have my water broken | |
| <input type="checkbox"/> Nipple stimulation | |

In the event that a Cesarean delivery should occur, I would like: Clear C-section drape
 Kangaroo Care in the operating room

Visitors I would like present during labor and delivery:

Other *(Please describe)*

BABY CARE

- | | |
|---|--|
| <input type="checkbox"/> Would like to have my partner cut the cord | <input type="checkbox"/> Delay cord clamp |
| <input type="checkbox"/> No pacifier or artificial nipples unless medically indicated | <input type="checkbox"/> May use pacifier (bring your own) |
| <input type="checkbox"/> Breastfeed <input type="checkbox"/> Bottle feed <input type="checkbox"/> Combination of both | |
| <input type="checkbox"/> Would like my partner to remain with my baby when my baby is not with me | |

*I understand that this plan may be altered due to changes in my condition or the condition of my baby.
I agree to have my MD/Midwife and Pediatrician sign my birth plan to indicate their agreement with my plan.*

SIGNATURE OF MOTHER

SIGNATURE OF FATHER

SIGNATURE OF MOTHER'S MD/MIDWIFE

SIGNATURE OF PEDIATRICIAN *(not required)*